



**NeuroDiagnostic Institute**

# EMERGENCY OPERATIONS PLAN

**Emergency  
Management**

2022

**Fulfills Joint Commission standard EM .01.01.01 and CMS standard 482.41(a). Aligns with the National Incident Command System and the Hospital Incident Command System**

## INTRODUCTION

The NeuroDiagnostic Institute's Emergency Operations Plan (EOP) explains how the hospital will manage its response to any incident that disrupts normal operations and may require outside assistance. The plan gives guidance from activation and notification to demobilization. The EOP is based upon an annual Hazard Vulnerability Analysis (HVA) and is intended to cover all hazards that are deemed likely to affect the hospital operations as well as staff and patient safety.

The EOP includes policies and procedures designed to address The Joint Commission Six Critical Areas:

- Communications
- Resources and Assets
- Safety and Security
- Staff Roles and Responsibilities
- Utilities
- Patient Services and Support

Finally, the EOP includes the establishment and maintenance of a training and exercise program. This program is designed to train staff on their responsibilities as well as test various parts of the plan through exercises and drills.

This EOP meets all Joint Commission and CMS standards and is aligned with the National Incident Management System (NIMS) and the Hospital Incident Command System (HICS). The EOP is a guide not a rigid procedure manual. The goal is: staff will know roles and responsibilities in a disaster, whatever the circumstances, in order to provide a safe environment and continuity of care

### **Plan Structure**

In order to facilitate ease of use, the EOP is prefaced by a Disaster Checklist for use in the first hour of an incident. The EOP Base Plan takes an "all hazards" approach outlining the hospital's response and recovery to a disaster. This includes policies and procedures for all employees and members of the Hospital Incident Management Team (HIMT). Following the Base Plan are a number of Annexes that provide plans, policies and procedures for specific hazards (such as bomb threat) and functions (such as evacuation). The EOP ends with Appendices that include an overview of the EOP, useful forms, and job aids.

# INITIAL INCIDENT CHECKLIST

## RESPOND TO ACTIVATION NOTIFICATION

### LEVEL:

*Advisory: Potential for a full activation exists*

- Prepare family, pets for your prolonged absence

*Alert: Conditions exist that make a full activation likely*

- Locate and check Go-Kit
- Prepare for immediate departure

*Activation: An incident has seriously degraded the function of the hospital requiring the activation of the Hospital Incident Management Team (HIMT)*

- Command Staff: Report to Incident Command (Exec. Conference room)
- General Staff: Report to your incident response position
- General Employees: Report to Conference Room C to check in and receive assignment.

## ATTEND TO ANY URGENT LIFE SAFETY NEEDS

### ASSESS YOUR RESPONSE AREA:

- Prepare to report initial status to Incident Command using NDI-7 form.
- Note fatalities, injuries, facility damage, resources needed
- Notify Incident Command if area is not functional - consider alternate site

### REPORT YOUR INITIAL STATUS

- Safety Officer: Conduct Initial Size-up
- Use form NDI-7 as a guide

- Use radio (Channel 1) or telephone (x4500)
- Report fatalities, injuries, facility damage, resources needed

### STABILIZE RESPONSE AREA

- Consider objectives in order to stabilize.

## ESTABLISHING INCIDENT COMMAND CHECKLIST

- Y Incident Commander signals Code White Activation of the incident Command (overhead page, Vocera, two-way radio, Live Process (LP)) to HIMT. Time: \_\_\_\_\_
- Y Incident Commander determines HIMT positions necessary to address the incident, staff the IC post. Time: \_\_\_\_\_
- Y Incident Commander directs:
  - o Safety Officer to perform Initial size-up..... Time: \_\_\_\_\_
  - o Planning Section Chief to begin assembling and display of Common Operating Picture (COP)..... Time: \_\_\_\_\_
  - o EM Technical Specialist to Open An Event Log on LP..... Time: \_\_\_\_\_
  - o PIO to begin drafting an initial statement to DMHA/FSSA officials as details emerge. Time: \_\_\_\_\_
- Y Incident Commander opens communication with DMHA/FSSA officials; standby while incident is stabilized, and a COP is created. Time: \_\_\_\_\_
- Y Incident Commander begins drafting an initial incident Action Plan (IAP) with incident objectives as details emerge.

# INCIDENT COMMUNICATIONS

FSSA	Communications Director	Gavin, James (Jim) Office: 317-234-0197 Cell: 317-319-9172
	Deputy Communications	Lemons, Marni Office: 317-234-5287 Cell: 317-407-3858
DHMA	Division Director	Chaudhary, Jay Office: 317-232-7860 Cell:
	Deputy Division Director	Norris, Katrina Office: 765-966-0511 x9292
Indianapolis Division of Homeland Security		Desk: 317-327-7511 Office: 317-327-3900 EOC: 317-327-7509 Watch Desk: 317-312-3566
District 5 Healthcare Coalition		
Indiana State Police HQ		317-899-8545
ISP Operations		317-232-8250
Non-emergency Ambulance		317-541-1200
IMPD		911 Office: 317-941-4470
NDI Superintendent		Cell: 317-995-5352
NDI Director of Operations		Office: 317-941-4080
Physical Plant Director		Office: 317-941-4011 Cell: 317-499-2402
Staff Development Director/ Emergency Management		Office: 317-941-4154 Cell: 317-417-5644

# HOSPITAL INCIDENT MANAGEMENT COMMUNICATION

Position	Location	Phone#
<b>Command Staff:</b>	Executive Conference Room (RM W-128) X4416	
➤ Incident Commander, <b>Chris Kerl</b>		<b>317-417-5644</b>
➤ Safety Officer, <b>Niki Brinker</b>		<b>317-966-0077</b>
➤ Liaison Officer, <b>Fred Madren</b>		<b>317-941-4007</b>
➤ Public Information Officer (PIO)		
➤ Technical Information Specialist (IT), <b>Darryl Bledsoe</b>		<b>317-519-2580</b>
➤ Medical Technical Specialist, <b>Dr. Michael Nicholas</b>		<b>317-519-2458</b>
➤ Emergency Mgmt. Tech Specialist, <b>Carl "Dan" Knapp</b>		<b>317-499-2402</b>
<b>General Staff:</b>		
➤ Operations Section, <b>Tim Gaalema</b>		<b>317-741-1909</b>
➤ Logistics Section, <b>Tim Gaalema</b>		<b>317-741-1909</b>
➤ Planning Section		
➤ Finance/Admin Section, <b>Justissa Elion-Epon</b>		<b>317-941-4052</b>
Resource Staging, <b>Tim Gaalema</b>		<b>317-741-1909</b>
Personnel Staging, <b>Lisa Canada</b>	Conference Room C	<b>317-941-4254</b>
Patient Care, <b>Unit Directors</b>	Director of Nursing Office	
➤ 2 East		
➤ 2 West		
➤ 3 East		
➤ 3 South		
➤ 3 West		
➤ 4 East		
➤ 4 West		
➤ 5 East		
➤ 5 West		

➤ 6 East		
➤ 7 East		
➤ 7 West		
Emergency Services,	Clinic	
Pharmacy, <b>Dennis Flanagan</b>	Pharmacy	<b>317-340-8538</b>
Security, <b>Niki Brinker</b>	Security	<b>317-966-0077</b>
Patient Tracking, <b>Jeffery Clearwater</b>	Conference Room C	<b>317-941-4195</b>
Food/Water, <b>Tim Gaalema</b>		<b>317-741-1909</b>

NDI 5 – Hospital Incident Management Team (HIMT) Organization Chart  
Rev. 2/2021

Liaison Officer  
Public Information Officer (PIO)  
Safety Officer  
IT/Communications Technical Specialist  
Medical Technical Specialist  
Emergency Management Technical Specialist

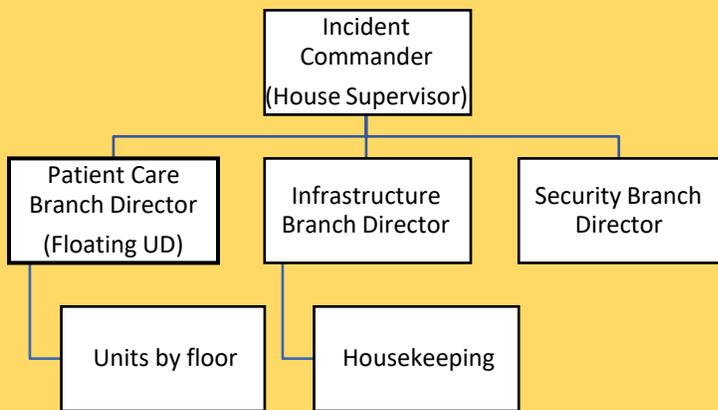
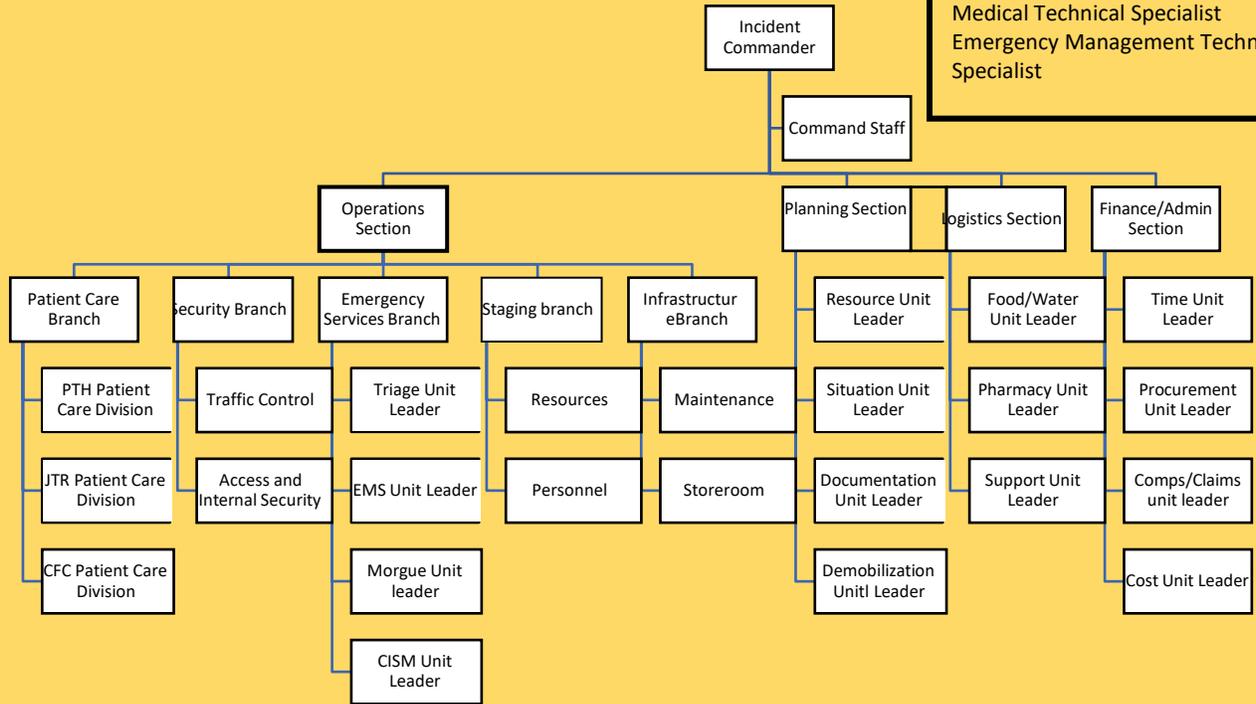


Figure 1 Hospital Incident Management Team: Evenings/Nights/Weekends

## Contents

INTRODUCTION.....	1
RECORD OF CHANGES.....	9
<b>Jurisdictional Profile.....</b>	<b>10</b>
Plan Objectives .....	11
BASE PLAN .....	11
PLANNING ACTIVITIES.....	11
Hazard Vulnerability Analysis.....	11
Emergency Operations Plan.....	12
<b>1.0 ACTIVATION OF THE PLAN .....</b>	<b>12</b>
1.1 Hospital Incident Command System (HICS).....	13
1.2 Activation of the Incident Command System .....	15
1.3 Roles of Key Personnel and Department Functions.....	16
1.4 Demobilization.....	19
<b>2.0 IMPLEMENTATION OF THE PLAN .....</b>	<b>19</b>
2.1 Management of Resources and Assets.....	19
2.2 Evacuation of the facility.....	20
2.3 Safety and Security .....	21
2.4 Staff.....	21
2.5 Volunteers/Disaster Privileges.....	22
2.6 Patients .....	23
2.8 Community Involvement .....	24
2.9 Continuity of Operations (see Annex for Additional Information) .....	25
<b>3.0 EVALUATION OF THE PLAN .....</b>	<b>26</b>
<b>4.0 COMMUNICATIONS PLAN .....</b>	<b>29</b>
Annexes to the Plan .....	31

Damage Assessment Annex .....	32
Hospital Evacuation Annex .....	35
Traffic and Security Annex .....	40
Workplace Violence Annex .....	41
Pharmacy Department Emergency Annex.....	46
Emergency Decontamination Annex .....	48
Bomb Threat Annex .....	49
Winter Storm Emergency Annex .....	52
Pandemic Infectious Disease Annex .....	55
PANDEMIC ALERT PERIOD.....	64
PANDEMIC PERIOD .....	66
General Employee Emergency Annex.....	78
2021 Continuity of Operations Plan (COOP).....	82
<b>Plan Appendices.....</b>	<b>83</b>
Appendix 1: Damage Assessment Tool .....	84
Appendix 2: Emergency Protective Measures Record.....	86
Appendix 3: Damage Assessment Guidelines .....	87
Appendix 4: Maps of Facility and Grounds .....	88
Appendix 5: Hospital Incident Management Team .....	96
Appendix 6: State Process for Restoration of Records .....	97
Appendix 7: Emergency HIPAA .....	99
Appendix 8: District 5 Healthcare Coalition General Information and Communications Plan .....	100
Appendix 9: Personnel Staging Screening Tools .....	101
Appendix 10: Evacuation Resources .....	104
Appendix 11: Forms .....	108

# RECORD OF CHANGES

#	DESCRIPTION	SECTION	DATE	SIGNATURE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
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17				
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## Plan Authorities

The NeuroDiagnostic Institute Emergency Operations Plan was created and revised under the authority of Emergency Management Council.

### **The plan was approved by the hospital's Emergency Management Council:**

Matt Foster, Hospital Superintendent  
Tim Gaalema, Hospital Director of Operations  
Chris Kerl, Emergency Management Council, Chair ✓  
Niki Brinker, Security/Safety Director  
Chris Kerl, Staff Development Director ✓  
Kellee Hawkins-Coleman, Clinical Director  
Fred Madren, NDI Chaplin/Educator ✓  
Oluwafemi Ijimakinwa, Quality Assurance Director ✓  
Todd Peters, Asst. Clinical Director  
Denis Flanigan, Chief Pharmacist  
Dr. Michael Nicholas, Physician ✓  
Lisa Canada, HR  
Cynthia Wilson, Director of Nursing  
Justissa Elion-Epon, Business Office Manager  
Jeffery Clearwater, HIS Director  
Cassandra Strong, Director of Social Work  
Carl "Dan" Knapp, Physical Plant Director  
Darryl Bledsoe, Information Technology Director  
Amy Frazer, Nursing Education Director ✓  
Lisa Passarelli, ADON ✓

Plan Revised: February 2022

Plan approved by the Emergency Management Council: 31 March 2022

- ✓ - indicates written approval of plan

## Jurisdictional Profile

NeuroDiagnostic Institute is a state-owned and operated inpatient psychiatric hospital managed by the Indiana Family and Social Services Administration and the Division of Mental Health and Addiction. It is accredited by The Joint Commission and participates in the CMS Medicare and Medicaid program. The hospital is located on the eastside of Indianapolis. The building is surrounded by Community East hospital to the south; Interstate 70 is approximately two miles from the building and is a major artery linking Indianapolis to Dayton, Ohio. The hospital has two entrances onto one road – East 16<sup>th</sup> Street which runs east and west. Although

NDI does not have an emergency department, the Community east hospital emergency department is located behind the building.

## Plan Objectives

The Emergency Operations Plan objectives are to:

1. Prevent or lessen the impact that an emergency may have on the institution and the community (mitigation).
2. Identify resources essential to disaster response and recovery and facilitate their access and utilization (preparedness).
3. Inform staff to respond effectively to an emergency or disaster situation that affects the environment of care (response).
4. Plan processes for re-establishing operations after the incident (recovery).

## BASE PLAN

### PLANNING ACTIVITIES

The hospital leadership participated and continues to participate in the formation, maintenance and exercising of this plan. Emergency Preparedness is a standing item on the Life Safety and Environmental Risk Prevention Sub-committee agenda and will meet as needed to address issues as they arise as well as plan exercises and update the plan.

*EM.01.01.01 EP1; EM.02.01.01 EP1*

### Hazard Vulnerability Analysis

*EM .01.01.01 EP2-6*

Recognizing that certain emergency situations are more likely to occur or to have an adverse impact on the hospital and as a part of its mitigation, and preparedness activities, NDI conducts an annual Hazard Vulnerability Analysis (HVA) designed to:

- Identify emergency situations that could occur and affect the hospital's ability to provide services.
- Assess the likelihood of these events occurring and the severity of those events to the operations of the hospital.
- Assess the hospital's preparedness to respond to and recover from them.

**Methodology:** The HVA is completed with input from members of the Emergency Management Council and uses the Kaiser Permanente HVA template. This document is then communicated to response partners in the District 5 Healthcare Preparedness Coalition.

## Emergency Operations Plan

EM .02.01.01

The Emergency Operation Plan provides an organized process to manage and sustain a response from a variety of emergencies, both external and internal. The plan is designed to assure appropriate, effective responses to a wide variety of emergency situations that could affect the safety of patients, staff and visitors or the integrity of the environment of NDI. The plan describes a comprehensive “all hazards” command structure for coordinating the six critical areas:

(1) communications, (2) managing resources and assets, (3) safety and security, (4) staff responsibilities, (5) utilities and (6) clinical activities. The overall response procedures will include single emergencies that can temporarily affect provision of care, along with multiple emergencies that can occur concurrently or sequentially that can adversely impact patient safety and the ability to provide care, treatment, and services for an extended length of time. This “all hazards” approach supports a general response capability that is scalable in order to address a range of emergencies of different duration and complexity. The plan’s response procedures are initiated in phases and address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience. The program is also designed to assure compliance with Joint Commission Standards and CMS Condition of Participation.

*“Let our advance worrying become advanced thinking and planning.” – Winston Churchill*

### **1.0 ACTIVATION OF THE PLAN**

**Disaster:** *An unexpected or sudden event that significantly disrupts the hospital’s ability to provide care, or the environment of care... - The Joint Commission*

In order to respond quickly and effectively, the hospital has adopted the Hospital Incident Command System (HICS) which is an incident management system that can be used by any hospital to manage threats, planned events, or emergency incidents. HICS is based on the same principles as the Incident Command System (ICS) component of the National Incident Management System (NIMS), adapted for the healthcare environment. The command structure of this model is the same used by community emergency response agencies. The primary responsibility of the command structure is to coordinate management of the six (6) critical areas of: Communication, Resources and Assets, Safety and Security, Staff Responsibilities, Utilities Management and Patient & Clinical Support activities during an emergency. HICS is an emergency management system comprised of key positions reflected on an organization chart. Each position has a specific list of responsibilities and actions (*Job Action Sheets*) to take prior (mitigation and preparedness) during (response) and after (recovery) an emergency. The HICS plan is designed to be flexible and when additional help is needed, fit into

the community, state, and/or national incident management systems. Only those positions, or functions, which are needed, should be activated. The ICS allows for the addition of needed positions, as well as the deactivation of positions at any time. The ICS may be fully activated for a large extended emergency, or only partially activated for smaller or more localized emergencies.

### **1.1 Hospital Incident Command System (HICS)**

The diagram below shows the hospital incident command structure. This structure is compliant with the National Incident Command System (NIMS) along with those of the District 5 Coalition and Marion County EMA.

This command structure is the Hospital Incident Management Team (HIMT).

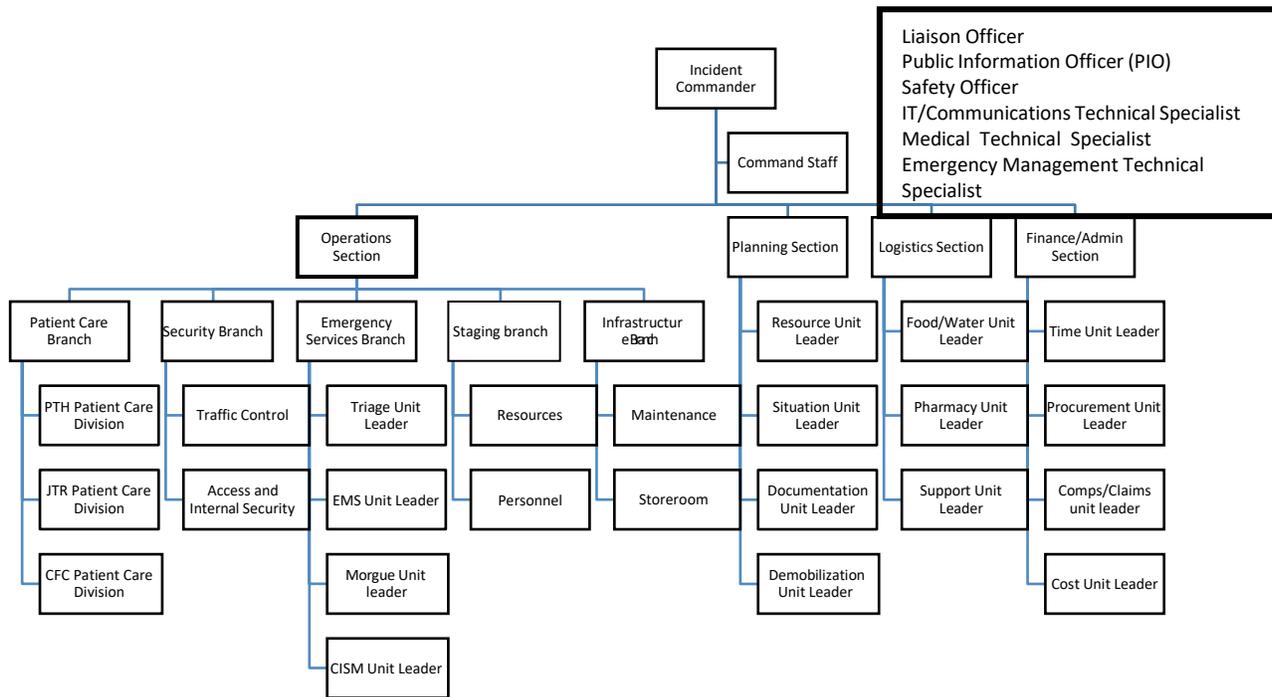


Figure 2 NDI-5 Hospital Incident Management Team (Organization Chart)

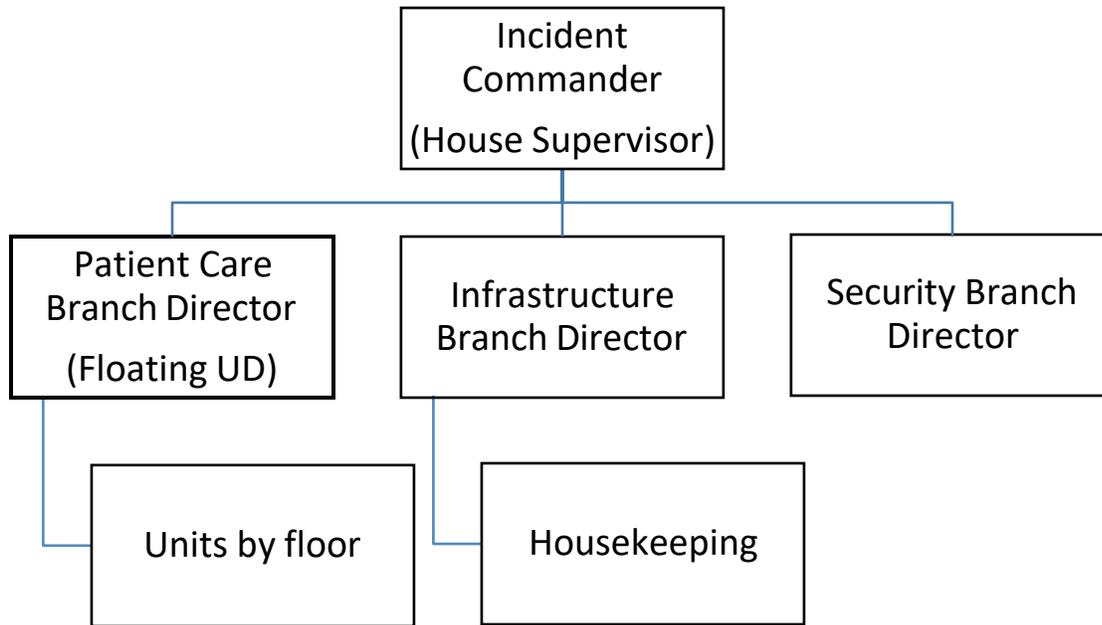


Figure 3 Hospital Incident Management Team: Evenings/Nights/Weekends

## Emergency Phases

The hospital Superintendent or designee will decide on the following levels of notification:

**Advisory**– Notification of Command and General Staff personnel that the potential for a full response exists. Incidents of this nature can be managed by staff on duty with little or no disruption to patient services. The HIMT ought to review their *Job Action Sheets* to be prepared in the event of escalation.

**Alert** – Notification of Command and General Staff personnel that a full response including activation of the Emergency Operations Plan is likely or imminent.

**Partial Activation** – Incident Commander has the flexibility to activate only portions of the HIMT as dictated by the type and severity of the emergency.

**Activation** – An incident has seriously degraded the functioning of the hospital requiring activation of the Emergency Operations Plan. Command and General Staff personnel ought to be prepared to immediately report to the Incident Command Center if notified. All other members of the HIMT should report to their response positions.

*All notifications should include the type and location of the incident as well as any reliable information concerning injuries or fatalities.*

## **1.2 Activation of the Incident Command System**

The Superintendent/designee or senior hospital staff member is responsible for initiating the response phase of the ICS when the emergency cannot be effectively managed utilizing normal hospital policies and procedures.

When the Hospital Incident Command System is initiated, the notification will be made by cell phone, Vocera, two-way radio, intranet and/or telephone and overhead paging system.

### **Initial Response**

When the Incident Command System is activated, the following procedures will be followed:

1. Upon arrival, the Incident Commander (IC) (Superintendent or designee) and Safety Officer (or designee) will:
  - Υ Do a size up using the **NDI-3 Incident Initial Size-up** form to establish situational awareness including:
    - Casualties - safety threats - need for evacuation or shelter-in-place
    - Initial damage assessment - threats to the environment
  - Υ Receive a summary of the **NDI -7 Situation Status Reports** from the Planning Section Chief (based on reports from every functional area of the hospital)
  - Υ Assume command by establishing an Incident Command Post
  - Υ Establish preliminary incident objectives, strategies, and tactics to prevent further loss of life, injury, and stabilize the situation
  - Υ Estimate resources needed
  - Υ Establish an initial incident response organization with an appropriate span of control to achieve incident objectives.
2. The IC will activate the Incident Command Post (ICP) using an **NDI-2 Incident Activation Form** and create a hospital Incident Action Plan (IAP) using **NDI-1 Incident Action (IAP) Cover Sheet or HICS 200 – Incident Action Plan (IAP) Cover Sheet** and **HICS Incident Action Plan (IAP) Quick Start** to begin to manage the incident.
3. The NDI IC will notify external stakeholders such as DMHA, District 5 Healthcare Coalition, and community emergency response agencies. The NDI IC will determine at what point to integrate the NDI response into a community Unified Command in consultation with appropriate agencies.
4. If the emergency situation occurs on evenings, nights, weekends or holidays, the nurse supervisor and security personnel will work together to fulfill the job duties of the IC, in order to manage the safety and security of the hospital until other hospital leaders arrive.

5. The IC will determine the necessary staffing of the Command and General Staff. Leadership personnel will manage and direct the operations specific to their assigned areas per their Job Action Sheet duties under the supervision of the NDI IC.
6. Upon completion of the Initial Response Phase, the organization will shift to Operational Response that will feature a planned, proactive response. This will be done in coordination with the Planning Section of the General Staff. The Planning Section Chief will establish a rhythm of operational periods in which a common operating picture will be assembled, and an Incident Action Plan will be written and disseminated.

### **1.3 Roles of Key Personnel and Department Functions**

EM .02.02.07

Staff roles and responsibilities as part of this plan were assigned by the Emergency Management Committee. For details of the preparedness and response activities of each position, see the *Job Action Sheet* for each position.

## **Command Staff**

### **Incident Commander (IC)**

Provides overall management of the incident by providing direction and guidance to the Command and General staffs. Reports to agency authorities.

### **Safety Officer**

Develops and recommends measures for ensuring personnel safety and to assess and/or anticipate hazardous and unsafe situations. Reports to Incident Commander.

### **Emergency Management Technical Specialist**

Advises Incident Commander and Command Staff on emergency management processes and procedures during an incident and is the hospital's liaison with the District 5 Healthcare Coalition Incident Coordination Center. Reports to Incident Commander.

### **Public Information Officer**

Develops and releases information about the incident-to-incident personnel as well as prepares information to be released to higher authorities. Reports to Incident Commander.

### **Information Technical Specialist**

To ensure the continuous flow of information during a disaster as well as the transfer and security of patient information. Reports to Incident Commander.

## **Liaison Officer**

To be a point of contact between the NDI Incident Command and the Community Health Network and food service provider. Reports to Incident Commander.

## **Medical Technical Specialist**

Advises Incident Commander on any issues that affect the continuity of patient care during an incident. Reports to Incident Commander.

# **General Staff**

## **Operations Section Chief**

Manages all operations directly applicable to the incident and supervises organizational elements according to the Incident Action Plan. Reports to Incident Commander.

- **Personnel Staging Area Manager**  
Manages all issues pertaining to staffing as well as coordinating the labor pool for the incident. This position is also responsible for the badging and credentialing of volunteers and licensed independent practitioners in accordance with Joint Commission Standards. Reports to Operations Section Chief.
- **Resources Staging Area Manager**  
Manages the ordering, tracking, and delivery of resources identified for use needed to support the incident. Reports to the Operations Section Chief.
- **Patient Care Branch Director**  
Oversees continuity of patient care for youth and adult patients during the incident. Reports to Operations Section Chief.
  - **Adult Patient Care Division Supervisor**  
Supervises continuity of care for adult patients. Reports to Patient Care Branch Chief.
  - **Youth Patient Care Division Supervisor**  
Supervises continuity of care for youth patients. Reports to Patient Care Branch Chief.
  - **Patient Care Unit Leader**  
Ensures continuity of patient care for his/her unit during the incident. Reports to Adult or Youth Patient Care Division Supervisor.
  - **Unit Care Staff**  
Ensures continuity of care for their patients during the incident. Reports to the Patient Care Unit Leader.
- **Infrastructure Branch Director**  
Implements Incident Action Plan concerning all areas of the physical plant and utilities.

Reports to Operations Section Chief.

- **Infrastructure Unit Leaders**  
Responsible for addressing the utility needs of the hospital during the incident particularly power and light, water and sewage, buildings and grounds, hazmat, and debris removal. Report to Infrastructure Branch Chief.
- **Emergency Services Branch Director**  
Supervises emergency medical services for patients, staff, responders, and volunteers. Reports to Operations Section Chief
  - **Emergency Services Unit Leaders**  
Coordinate the triage, treatment, and handling of remains of patients, staff, responders, and volunteers. Report to Emergency Services Branch Chief.
- **Security Branch Director**  
Provides traffic/crowd control, perimeter security; ensures secure access control into the facility and is the facility's interface with law enforcement. Reports to Operations Section Chief.

### **Planning Section Chief**

Collects, evaluates, disseminates, and displays incident information. Reports to the Incident Commander.

- **Patient Tracking Unit Leader**  
Maintains accurate census of patients who are either sheltering in place or have been evacuated. Reports to Personnel Staging Area Manager.

### **Logistics Section Chief**

To provide facilities, services, and material support for the incident. Reports to Incident Commander.

- **Support Unit Leader**  
Supervises the supply, facilities, and ground support needed to support the incident. Reports to the Logistics Section Chief.
- **Food/Water Unit Leader**  
Ensures access to food and water for patients, staff, responders, and volunteers during the incident. Reports to Logistics Section Chief.
- **Pharmacy Unit Leader**  
Ensures access to medications for patients during the incident. Reports to Logistics Section Chief.

### **Finance and Administration Section Chief**

Manages all financial, administrative, and cost aspects of the incident. Reports to the Incident Commander.

## **1.4 Demobilization**

The Incident Commander will make the decision to demobilize. The Planning Section will initiate demobilization by which the hospital will return to normal operations and begin the recovery process. A critical part of demobilization will be debriefing and submission of After-Action Reports (AAR) by incident staff in order to capture lessons learned and evaluate the effectiveness of the plan. This will be the responsibility of the Incident Commander in cooperation with the Planning Section Chief.

## **2.0 IMPLEMENTATION OF THE PLAN**

### ***2.1 Management of Resources and Assets***

*EM.01.01.01*

#### **Inventory of Assets and Resources**

The organization maintains an inventory of assets and resources on site that could be used in the event of an emergency. The inventory includes, but is not limited to, the following:

- Personal protective equipment
- Water
- Food
- Linen
- Medical supplies
- Pharmaceutical supplies
- Transportation vehicles
- Staff support supplies

#### **Resource Management**

The hospital maintains an inventory of resources and assets needed in an emergency. This inventory is managed by the Logistics Section Chief and is available within a few minutes. Additional resources for patient/staff food and water are maintained by CHE in compliance with regulatory requirements. It is the responsibility of the NDI Liaison Officer to audit and supervise the plan.

In an emergency, resources will be requested through the Logistics Section Chief and sent to the Resource Staging Area for dissemination. All resource requests must be documented and

tracked according to FEMA guidelines for accountability to the Finance and Administration Section Chief.

## **2.2 Evacuation of the facility**

*EM .02.02.03 EP 9 and 10*

In all disasters, evacuation will be to the nearest safe area as determined by the Incident Commander and/or Safety/Security Officer. **ELEVATORS ARE NOT TO BE USED DURING EVACUATION.**

The Incident Commander or designee will make the decision to Shelter-in-Place, partially evacuate, or fully evacuate the facility with the primary concern being the safety of patients and staff.

### **Shelter-in-Place**

Unit staff will stay with the patients in alternative areas on the unit. All patients will be accounted for and will remain in the shelter area until the “all clear” is heard.

### **Partial Evacuation**

Unit staff will assemble the medical records, medications, and personal belongings for transfer off a unit. Evacuation sites may include but are not limited to: Multi-purpose rooms: W-250, W258, C-416, C-516, and W-630. (C-516 is contingent with Community Hospital East’s EOP)✓ Additional beds will be obtained from the storage area and linens from the laundry. Assistance will be provided from other work areas; personnel, maintenance, security, and housekeeping staff may be detailed from Personnel Staging in order to safely relocate the patients and make a safe and secure transfer of medications and medical records.

The Incident Commander will notify DMHA to consider what SPH to transfer patient to.

### **Full Evacuation of the Facility**

In the event of a major disaster in which the facility can no longer provide safe care and/or housing for the patients, the Division of Mental Health and Addictions will be notified. The decision to evacuate shall be made by the IC in collaboration with the senior positions of the Command Center team. In addition, there will be appropriate communication and collaboration with District 5 Healthcare Coalition as well as state and local emergency management agencies.

*See Evacuation Annex for more details*

## **2.3 Safety and Security**

EM .02.02.05

During an emergency, the Safety/Security Officer, working with the Incident Commander, will implement contingency plans to secure the facility, areas within the facility and manage vehicular and pedestrian traffic, based on the needs of the specific situation.

Maintenance staff who report to the personnel pool may be used to augment the security forces if the situation warrants. They will receive just-in-time training. When appropriate, local, state law enforcement will assist as needed. In addition, in the event of a need for a security surge, Securitas has agreed to furnish additional guards and vehicles; present customers receiving priority.

*See Emergency Traffic /Security Plan Annex and for further details.*

## **2.4 Staff**

EM.02.02.07

Each area Department Head/Division Director is responsible for ensuring that each employee in their area is aware of the Emergency Operations Plan and their role.

When emergency plans are implemented, a number of methods are used to notify affected staff. Primarily within the hospital, staff will be notified by Vocera, overhead page, telephones, and two-way radios. The hospital will notify staff away from the facility via, telephone, text and the agency communications alert:

[https://public.govdelivery.com/accounts/INFSSA/subscriber/new?topic\\_id=INFSSA\\_5](https://public.govdelivery.com/accounts/INFSSA/subscriber/new?topic_id=INFSSA_5)

The Incident Command System is used to assure that each implementation of the emergency plan includes staff as needed to effectively activate the plan. The system is based on the use of *Job Action Sheets* and an organizational chart to assure that each task is considered, and that staff is made available to complete those tasks. The organizational chart assists the IC in allocating the available staff, to look ahead and determine when more staff should be called in, as well as when staff on duty should be relieved to provide rest and breaks. Those identified as members of the Hospital Incident Management Team receive appropriate training for their roles, along with subsequent drills to ensure proficiency. Other staff, who may be asked to perform tasks other than those normally performed, receive training in advance or just-in-time training at the time of the incident/exercise.

When the Incident Command System is established the ICS organizational chart and *Job Action Sheets* are used to assure critical task positions are filled first and as other staff members become available, they are assigned to the most critical jobs remaining.

- **Staff Support**

*EM .02.02.07*

- **Housing:** Staff will be housed at the hospital on vacant units, conference rooms, and school rooms. An inventory of cots, blankets, and sleeping bags is maintained.
- **CISM:** The hospital has a Critical Incident Stress Management team. This team has been trained in the methods recommended by the International Critical Incident Stress Foundation in supporting staff following any size critical incident. The team has a coordinator and procedure for deployment. The State of Indiana also maintains the *Employee Assistance Services for You* program that provides employee and family member confidential support during difficult times by phone (1-800-223-7723) or at <http://www.in.gov/spd/2466.htm>

## **2.5 Volunteers/Disaster Privileges**

*EM.02.02.13, 15*

All volunteers as well as incoming staff will be directed to the Personnel Staging Area primarily located in the Conference room A or the area designated by the IC. Here, personnel will be screened, and credentialed. Licensed Independent Practitioners will be credentialed by Personnel Staging officials using Indiana Online Licensing.

Section A of the Special Status Privileges in the *NDI Medical By-laws* provides additional detail:

- **Disaster Privileges**

- a. Disaster privileges may be granted by a Medical Director or the Campus Medical Professional Executive Committee (MPEC) or designee(s) when a campus disaster plan has been activated and the campus hospital is unable to meet the needs of patients.
- b. Disaster privileges may be granted to volunteers on a case-by-case basis and upon presentation of any of the following:
  - i. Current hospital ID card that clearly identifies professional designation
  - ii. Current license to practice and a valid picture ID issued by a state, federal, or regulatory agency
  - iii. Verification that the individual is a member of a disaster relief team
  - iv. State, federal, or municipal identification indicating the individual has been granted authority to render patient care, treatment, and services in a disaster situation

- v. Presentation by a current Medical Professional Staff Organization (MPSO) member with personal knowledge of the individual's identity and ability to act as a LIP during a disaster
- c. The volunteer will wear a name tag identifying him/herself as a volunteer practitioner. The volunteer will be under direct observation and monitoring by a designated MPSO member.
- d. Volunteers granted disaster privileges must abide by these Bylaws, Rules & Regulations, and campus policies.
- e. Within seventy-two (72) hours of a declared disaster, the Medical Director or MPEC will determine whether disaster privileges should continue.
- f. As soon as the disaster is under control, or within seventy-two (72) hours of volunteer presence, whichever occurs first, the primary source verification process will begin for credentialing of the volunteers who received disaster privileges. The verification process outlined in NDI Medical Staff Bylaw Policy, under the Special Status Privileges section, will be utilized at the campus level.
  - i. In extraordinary circumstances, verification may not be possible within seventy-two (72) hours. In such circumstances (e.g., no means of communication or lack of resources), the Medical Director or MPEC must document why primary source verification could not be completed within seventy-two (72) hours, provide evidence of the volunteer's demonstrated ability to provide adequate care, treatment, and services during the disaster, and document attempts made to perform primary source verification as soon as possible.
  - ii. Verification is not required if the volunteer does not actually provide care, treatment, or services under the disaster privileges.

The performance of volunteer practitioners who receive disaster privileges will be monitored via direct observation, mentoring, and clinical record review by members of the medical staff. Volunteer practitioners granted disaster privileges will receive an identifying hospital ID.

## **2.6 Patients**

### *EM .02.02.11*

Different emergency situations or types of disasters require different patient management strategies. The Patient Care Branch Chief will work with the Emergency Services Branch Chief to tailor the patient management strategies to the particular emergency.

During an emergency, staff and patients who are victims of a disaster will be triaged to determine their necessary level of care. Patients who need immediate medical assistance will be sent to the Emergency Services Branch for stabilization. Patients whose clinical needs fall

outside of the scope of services or ability of the organization to care for them should be promptly identified and transferred to a healthcare facility equipped to provide appropriate care. See *Job Action Sheet* for Emergency Services Director for more details.

### **Patient Hygiene and Sanitation Needs**

The Patient Care Division Directors and Unit Division Supervisors will be responsible for assuring that patient hygiene and sanitation needs are met for the duration of the emergency.

## **2.7 UTILITIES**

*EM .02.02.09*

Indianapolis Power and Light provide electrical power supply to the hospital building. This is done with two 13,200-volt feeds equipped with switching gear to sense a phase loss. This protects Phase 3 equipment from damage and guarantees transfer to the alternate feed when necessary. During an emergency, the organization will identify alternate means for providing essential utility systems. These utility systems will be identified as well as alternate means for providing services. The organization will assess the requirements needed to support these systems such as fuel, water, and supplies for a period identified in the Inventory of Assets. This information will assist the hospital with the identification of capabilities and establish response procedures for when the hospital cannot maintain adequate utilities.

Alternate means of providing essential building utility needs include:

- Water: Water is furnished by Citizen’s Energy Group with one feed to the entire building both for domestic and fire suppression systems.
- Electricity: The electric power is furnished by AES Indiana fed from two 13,200 KV substations located off-site. The facility is equipped with one emergency back-up generator to supply emergency electrical power to the hospital area. IT services utilize UPS to manage outage between IPL loss and Generator pickup.
- Ventilation: No alternative
- Fuel: Primary source natural gas—Note: Boiler #1, #2, and #3 can operate on alternative fuel.
- Medical Gas: Oxygen is supplied through the wall with a shut off valve; and O2 suction.

## **2.8 Community Involvement**

*EM.02.02.01 EP 8-12; .02.02.03 EP 1, 4, 5; .02.02.11 EP 4; .03.01.03*

NDI is a voting member of the ***District 5 Healthcare Preparedness Coalition***, a consortium of over thirty hospitals in Central Indiana to share lessons learned, discuss emerging threats, receive Assistant Secretary for Preparedness & Response (ASPR) grant funds, and participate in community-wide exercises. NDI will also work with the Marion County Health Department, the Marion County Emergency Management Agency, the Indiana State Department of Health, and

the Indiana Department of Homeland Security to assist in community disasters or receive assistance in the event of a disaster at the facility or in the community. *The Marion County Comprehensive Emergency Management Plan does not require NDI to receive casualties or patients.* NDI, in cooperation with the Marion County Health Department, operate a “closed POD” in order to receive pharmaceuticals from the Strategic National Stockpile. In the event of a disaster situation in other Indiana locations, NDI would be available to assist with patients or staff relocation from other State Operated Facilities. This might include office space or housing and care for the patients. Additional beds are available. Housing could be arranged in either gym area, multipurpose rooms or on patient units, depending on current vacancies. If NDI would need to transfer patients to another State Psychiatric Hospital, buses would be arranged for transport. The receiving State Psychiatric Hospital include sites in Richmond, Logansport, Evansville, and Madison.

NDI, during a community disaster situation, can provide the following services based on providing for the hospital’s inpatient requirements first.

1. Medical supplies and pharmaceuticals would be limited to bandages, oral and topical medications, based on type of patients this hospital serves and the inventory on hand.
2. A limited supply of food and water could be provided by CHE. (CHE hospital maintains approximately 96 hours inventory of food and water on hand for the patient population).
3. Services provided include: Power plant, laundry, cold storage, water system, emergency generator, nursing, and physician care. Our patient load must be considered. This is based on 7 days a week, 24 hours a day operation. Staff: A member of the hospital’s staff would be appointed by the IC to be the liaison with the District 5 Incident Coordination Center during community disaster situations for resource support.

*NeuroDiagnostic Institute is a state Psychiatric Hospital and as such cannot accept patients from any other facilities other than those from the State Psychiatric Hospitals.*

## ***2.9 Continuity of Operations (see Annex for Additional Information)***

The purpose of a COOP is to maintain essential business operations during a disaster situation. The Emergency Operations Plan (EOP) lays out how the organization will prepare, mitigate, and respond to a disaster. Although the COOP is activated during the Recovery phase, consideration of continuing vital operations is necessary at the beginning of a disaster.

***Essential Functions*** of the hospital include maintenance of environment of care, patient & employee safety, and essential business functions.

***Order of Succession:*** In the event of the inability of the hospital superintendent to fulfill his/her duties the line of succession would be the Operations Director then Service Line Managers.

***Delegation of Authority*** would be essentially determined by officials at the Division of Mental Health and Addition.

**Continuity Facilities:** In the event of a disaster requiring the full evacuation of the facility, patients and essential staff would be transferred to one of the other State Operating Facilities.

**Continuity Communications** include Vocera, hand-held radio, telephone, and email. All response positions have emergency contact lists to draw from.

**Vital Records Management** is maintained by the Health Information Services Department which maintains processes and procedures for the protection and transfer of patient records under policies of the DMHA and FSSA in compliance with HIPAA.

**Human Capital:** In order to maintain necessary staffing in an emergency, staff are educated on personal and family emergency preparedness and their duty to respond in the event of a disaster and FSSA emergency notification.

**Testing, Training, and Evaluation** is part of the Multi-year Training and Exercise Plan.

**Devolution** would be under the authority of DMHA and FSSA COOP.

**Reconstitution** would also be accomplished under the authority of DMHA and FSSA COOP.

**1135 Waivers:** A waiver to request approval of continuity of care at an alternative site during an emergency would be initiated by DMHA.

“Training reduces staff anxiety and promotes understanding of roles and responsibilities.” - TJC

### 3.0 EVALUATION OF THE PLAN

EM.03.01.01, EP 3

NDI will annually evaluate its **Hazard Vulnerability Analysis (HVA)**, the objectives and scope of its Emergency Operations Plan (EOP) and its inventory of emergency supplies. This review will be forwarded to senior hospital leadership for review. In compliance with Joint Commission Standard EM.03.01.03, NDI will conduct exercises to assess its Emergency Operations Plan. The Emergency Operations Plan will be activated semi-annually. A full-scale exercise of the plan will be conducted once per year in cooperation with the District 5 Healthcare Coalition. Other parts of the plan will be exercised as part of a **Multiyear Training and Exercise Plan** designed and supervised by the Emergency Management Committee. These exercises will evaluate the hospital’s handling of communications, resources and assets, security, staff, utilities, and patients. The exercises will be evaluated by the Emergency Management Director and members of the Emergency Management Committee. Exercises will be followed by an After-Action Review (AAR) to capture lessons-learned and reported in a written After-Action Report. From the report, an Improvement Plan (IP) will put into place for improvements identified in the exercises. All plan exercises will conform to the FEMA HSEEP methodology.

The hospital training and exercise plan includes both initial and refresher training for all staff members as well as members of the Hospital Incident Management Team (HIMT). This training includes:

- New employee orientation – basic emergency management principles, handouts of general emergency operation handbooks, and viewing of Med sleds and active shooter training videos.
- Maintenance of HIMT job action sheets
- Monthly District 5 Healthcare Coalition meetings and communication tests.
- Monthly hospital communication test using Two-Way Radio.
- Annual full unit evacuation drills.
- Periodic TTX of a HIMT section such as emergency services, command staff, resource management or personnel staging.
- Annual employee refresher as part of the annual required training.

### **Definitions**

**After-Action Report (AAR)** - A narrative report that presents issues found during an incident and recommendations on how those issues can be resolved.

**COOP** – Continuity of Operation Plan.

**Designee**- One who is empowered with responsibility and authority to act during a COOP activity by a designated official.

**Disaster** -A disaster is a type of emergency that, due to its complexity, scope, or duration, threatens the organization’s capabilities and **requires outside assistance** to sustain patient care, safety, or security functions.

**Disaster Privileges** -\_Privileges granted to licensed independent practitioners when the Emergency Operations Plan is implemented.

**Emergency**- An emergency is an unexpected or sudden event that significantly disrupts the organization’s ability to provide care, or the environment or care itself, or those results in a sudden, significantly changed, or increased demand for the organization’s services. Emergencies can be either human-made or natural or a combination of both, and they exist on a continuum of severity.

**Emergency Operations Plan (EOP)**—A written document describing the process that would be implemented to manage the consequences of emergencies, including natural and human-made disasters, which could disrupt the organization’s ability to provide care, treatment, and services

**Hazard Vulnerability Analysis (HVA)**-The identification of potential emergencies and the direct and indirect effects these emergencies may have on the hospital's operations and the demand for its services.

**HIMT** –Hospital Incident Management Team is made up of staff who have specific roles in a disaster that may be different from their usual positions.

**Hot Wash** - An information activity that takes place after a disaster response or an exercise simulating a disaster. Its purpose is to identify problems and possible solution for improving future responses. Observation and recommendations are used to develop the "After Action Report".

**Incident Command System-(ICS)** The combinations of personnel, procedures, communication, equipment, and facilities, operating within a common organizational structure, designed to aid in incident management activities.

**Mitigation** -activities designed to reduce the risk of and potential damage due to an emergency (i.e., the installation of standby or redundant equipment, training).

**National Incident Management System-(NIMS)** - A system used in the United States to coordinate emergency preparedness and incident management among various federal, state, and local agencies.

**Preparedness**- activities undertaken to organize and mobilize essential resources (i.e., plan writing, employee education, preparation with outside agencies, acquiring and maintaining critical supplies).

**Recovery**-activities that the hospital undertakes to return the facility to complete business operations. Short-term actions assess damage and return vital life-support operations to minimum operating standards. Long-term the focus is on returning all hospital operations back to normal or an improved state of affairs.

**Response**-activities the hospital undertakes to respond to disruptive events. The actions are designed with strategies and actions to be activated during the emergency (i.e., control, warnings, evacuation).

**Staging**-The Personnel Staging Area is the gathering place where all available employees report and await instructions from the NDI IC or the section leader of the Operations Section. The staging area location will be dictated by current circumstances.

## 4.0 COMMUNICATIONS PLAN

### Hospital Communications: Internal and External

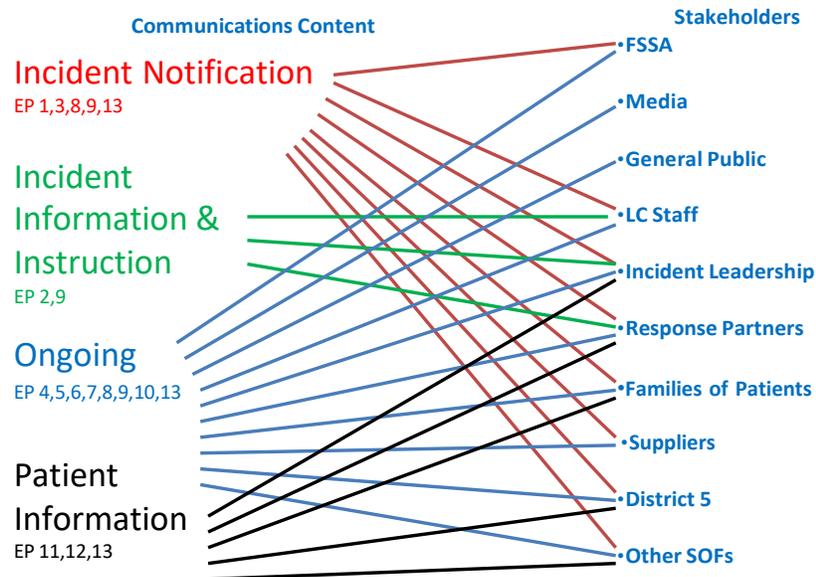
EM .02.02.01

The illustration below (Figure 1) details stakeholders for:

- Notification: Who ought to be initially notified that the Emergency Operations Plan is in effect?
  - Incident information and instruction: Who will need incident information and instruction in order to perform response activities?
  - Ongoing incident communication: Who ought to receive progress reports and briefings?
  - Patient information: Who ought to receive information regarding the status and location of patients?
- (See Appendix for memoranda concerning release of patient information to responders).

Figure 1

### JC Communications Requirements: Content and Stakeholders Web



This plan provides for notification and ongoing communication with a variety of stakeholders (See Figure 1). The table below shows the methods for notification and ongoing communication.

Stakeholder	Method of Notification	Method of Ongoing Updates
Staff on duty	Vocera, Overhead Announcement/Runner, Two-Way Radio	Vocera/Runner, Two-Way Radio
Staff at home	Agency email/text	Agency email /text
Patient Families	Social Workers/Agency Website	Social Workers/Agency Website
Agency & Department Officials	Text/Email	Text/Email
Medical Staff	Agency email/text	Agency Website/text
District 5 Coalition Partners	LiveProcess/EMResource	LiveProcess/EMResource
External Emergency Agencies	EMResource	EMResource
Media	Refer to Agency Communications Office	Refer to Agency Communications Office

## **Annexes to the Plan**

The NDI Emergency Operations Plan features the following plan annexes:

- Damage Assessment
- Evacuation
- Traffic and Security
- Workplace Violence
- Pharmacy
- Emergency Decontamination
- Bomb Threat
- Winter Storm Emergency
- Pandemic Infectious Disease
- General Employee
- 2022 Continuity of Operations Plan (COOP)

## **Damage Assessment Annex**

### **Purpose**

This annex provides guidance for the assessment and reporting of physical damage to NDI resulting from disasters. Damage assessment will help establish priorities for the allocation of resources, identify requirements for conducting recovery operations, assist in the documentation necessary for application for public assistance, as well as supply data for the disaster declaration process.

### **Assumptions**

- A damage assessment effort will be initiated as soon as practical following the occurrence of a disaster.
- Photographs will be taken of damaged areas and maps will be used to show the location and extent of damage.
- When damage assessment is carried out in conjunction with a request for state or federal disaster assistance, the Hospital Emergency Coordinator and Business Office Manager will coordinate with DMHA, FSSA, Marion County EMA, IDHS, and FEMA.
- The Physical Plant Director and Business Office Manager will participate in damage assessment procedure training.
- The Physical Plant Director and Business Office Manager will collaborate together to form, train, and maintain Hospital Damage Assessment Team(s).
- The Physical Plant Director will maintain photographs and maps that will serve as a baseline for initial damage assessments to be updated annually.
- Damage assessment will be incorporated where possible into Emergency Management Program drills and exercises.
- NDI damage assessment will follow the FEMA 4 Point System for evaluating damage: (see *Damage Assessment Level Guideline* for more detail)

<b>Damage Definition</b>	<b>General Description</b>
<b>Destroyed</b>	
Structure is a total loss, <i>Not economically feasible to rebuild.</i>	Structure leveled above the foundation, or second floor is gone. Foundation or basement significantly damaged.
<b>Major</b>	
Structure uninhabitable. Extensive repairs necessary to make habitable. <i>Will take more than 30 days to repair.</i>	Walls collapsed. Exterior frame damaged. Roof off or collapsed. Major damage to utilities: boiler, chillers, water system, sewage.
<b>Minor</b>	
Structure damaged and uninhabitable. Minor repairs necessary to render habitable. <i>Will take less than 30 days to repair.</i>	Interior flooring/exterior walls with minor damage. Tree(s) fallen on structure. Shingles moved or missing.

Affected	
Received minimal damage. Habitable without repairs	Outside Terrace, Carpet on firstfloor soaked. Broken windows.

- The prompt and accurate assessment of damage to property following a disaster will be of vital concern to officials.
- Comprehensive damage assessment evaluation is necessary to support requests for recovery programs offered at the state and federal levels. An accurate damage assessment will also support post disaster mitigation efforts that would make NDI more resilient in the future.
- Higher levels of government will provide assistance in developing damage assessment reports to support requests for major disaster declarations.

### Concept of Operations

Damage assessment at NDI consists of two phases:

1. **Rapid Damage Assessment** (Windshield Survey) is conducted immediately after an event. This assessment focuses on immediate life-threatening situations. This initial size-up provides the incident commander with information to assess the size of the event, extent of the damage and to prioritize response activities along with creating a common operating picture **NDI-8 -Common Operating Picture**.
2. **Initial Damage Assessment: NDI-4 – Damage Assessment Tool** helps to provide additional, more detailed information to determine if an emergency declaration is required and if assistance from other jurisdictions will be required. This should be completed within 72 hours of the event.

NDI damage assessment teams are located on the Emergency Response Organizational Structure as units reporting to the Buildings and Grounds Group Leader who reports to the Infrastructure Branch Chief. The Buildings and Grounds Group Leader will be responsible for deploying Damage Assessment Team(s) to ensure that an assessment is completed of the impacted areas to determine the extent of damage, the types of structures impacted and the overall area that has been affected. Damage assessment data, like all other incident documentation, will flow to the Planning Section Chief.

### Emergency Protective Measures/Debris Removal

In addition to documenting the damage sustained, it is important that a thorough account is kept of emergency protective and debris removal measures. During incidents where a presidential disaster declaration has occurred, reimbursement may be available for resources

committed to assist in emergency operations or to cleanup from the incident. This should include an accounting of number of employees and their hours as well as any equipment used.

### **Training and Exercises**

The Physical Plant Director, Infrastructure Branch Chief, Buildings and Grounds Group Leader, Business Office Manager, and Damage Assessment Team members shall complete FEMA course IS-559: *Local Damage Assessment*, or equivalent, as well as other related trainings as they become available. When possible, damage assessment should be included in exercises and/or drills.

### **Establishing a Baseline**

The Physical Plant Director should take photos of the exterior condition of buildings to archive as a baseline in order to verify structural conditions pre-event.

### **Assessment Zones**

The Physical Plant Director should divide the building and grounds into zones to be assigned to teams in a pre-assessment briefing to prevent duplication of effort.

See Appendix 1: *Rapid Damage Assessment Tool*

Appendix 2: *Protective Measures and Debris Removal Form*

Appendix 3: *Damage Assessment Level Guidelines*

## ***Hospital Evacuation Annex***

Like many topics in emergency management, evacuation seems fraught with so many possible contingencies that one hesitates to plan at all. However, there are a number of issues that can be addressed ahead of time; if not hard and fast rules, guiding principles:

- Full evacuation of a hospital should generally be considered as a last resort; decision-makers ought to have a variety of middle steps between Shelter-in-place (SIP) and full evacuation.
- Safety is always the primary concern.
- Simplicity is key; the staff will need a simple plan to follow in an emergency.
- Flexibility is vital because the procedures must be able to be adapted to a variety of situations.
- Self-sufficiency at the unit level is important because timely communication from hospital leaders may be difficult or even impossible, requiring employees at every level to know immediately what to do in their area.
- NDI staff will be prepared to evacuate internally, externally; long-term, short-term; partially or the entire hospital. In the event of a disaster that overwhelms the hospital's resources, NDI will call upon partners within the District 5 Healthcare Coalition, Indianapolis Division of Homeland Security, and the Indiana Department of Homeland Security for resources.
- An evacuation at any level will lead to at least a partial activation of the Hospital Incident Command Structure.
- When difficult choices must be made, leaders and staff must focus on the "greatest good for the greatest number."

### **Decision-making and Notification**

#### **Decision-making**

After receiving an initial size-up from the Safety Officer and/or Security, the decision to evacuate all or part of the hospital will be made by, in order of succession:

1. Hospital Superintendent
2. Hospital Assistant Superintendent
3. Safety Officer
4. Senior Nursing Personnel

The decision to evacuate will be up to the discretion of the decision-maker guided by the following list of scenarios:

- Fire and smoke
- Facility or structural damage
- Potential or real exposure to hazardous materials
- Credible bomb threat

The decision to evacuate need not be an all or nothing action. Partial evacuations include: horizontal evacuation to another area of that floor; vertical evacuation to another floor; the evacuation of one unit or one area of the hospital while operations continue unaffected in the remainder.

### **Evacuation Communication: Notification and Ongoing**

Communications with the following stakeholders including methods of notification and ongoing updates:

Stakeholder	Method of Notification	Method of Ongoing Updates
Staff on duty	Vocera, Overhead Announcement/Runner, Two-Way Radio	Vocera/Runner, two-way radio
Staff at home	Agency email/text	Agency email /text
Patient Families	Social Workers/Agency Website	Social Workers/Agency Website
Agency & Department Officials	Text/Email	Text/Email
Medical Staff	Agency email/text	Agency Website/text
District 5 Coalition Partners	LiveProcess/EMResource	LiveProcess/EMResource
External Emergency Agencies	LiveProcess/EMResource	LiveProcess/EMResource
Media	Refer to Agency Communications Office	Refer to Agency Communications Office

## Evacuation Conduct

### Evacuation Coordinators

Decisions concerning the conduct of an evacuation, partial or full; internal or external, temporary, or long-term, will be the responsibility of two **Evacuation Coordinators**. The Evacuation Coordinators will make decisions pertaining to the following issues:

- use of stairs or elevators
- order of evacuation of patients/units
- equipment to be used especially the use of wrist-to-waist for patients who are in restraint at the time of the incident\*
- transport of patient records
- transport of patient medications in cooperation with pharmacy
- evacuation route
- staff roles and responsibilities
- personal items for patients to take with
- any other issue affecting the conduct of an evacuation

\* RNs and Bridge Building instructors are trained on the use of wrist-to-waist restraints. These are only to be used in case of emergency and will always have a 1:1 escort to ensure the safety of the patient.

The hospital positions that will fill the role of Evacuation Coordinators are the ADONs and Unit Supervisors who are the Youth Patient Care and Adult Patient Care Division Supervisors in the Incident Command Structure:

- The Hospital Evacuation Coordinators will collaborate with the Hospital Emergency Coordinator to train staff and exercise this plan.
- Food and water for evacuated patients as well as staff and first responders will be secured from CHE.
- Security for evacuations will be handled by security staff under the supervision of the Security Director.
- Evacuation Coordinators are encouraged to request additional staff from the labor pool in the Personnel Staging Area located in Conference room A or designated area.
- Patient medications will be accessed per pharmacy emergency plans.
- Evacuation Coordinators are encouraged to work with the Social Work Director and Hospital Superintendent or designees to expedite leaves of absence for patients eligible to do so and if time permits.

## Relocation and Surge

### Relocation

Type	Destination	Contact
Acute/Long term	Another State Psychiatric Hospital	DMHA/FSSA
Non-acute/Short term	NDI Treatment Mall/Gym/Multi-purpose rooms/Outside facility	Evacuation Coordinators/D5 Healthcare Coalition/Indianapolis Homeland Security/IDHS EOC
Acute/Short term	Community Hospital East/Area general hospital	DMHA

\*IC 12-26-11-1 allows patients to be transferred to any other facility as long as the transfer is in the best interest of the patient or others. The transfer doesn't have to be another SPH but must be within the State of Indiana.

### Transportation

Need	Source
Partial up to 1 Unit	Hospital vehicles
Greater than 1 Unit or Full Evacuation	D5 Command Center, Indianapolis Division of Homeland Security, Indiana Department of Homeland Security

**\*Drivers will be NDI staff for all hospital vehicles.**

### Surge

NDI has the capability to accept psychiatric patients evacuated from other SPHs only. This would trigger an activation of the hospital ICS. Surged patients would be admitted by Emergency Services through the Sally-port.

### Patient Tracking

Staff will use the HICS 260 Patient Evacuation Tracking form or a modification to track patients moving throughout the facility, leaving the facility, and/or entering from another facility. The Patient Tracking Unit Leader must maintain situational awareness of the location and status of all patients both internal and surged.

### Communication

Vehicles transporting patients will stay in constant contact with the hospital Incident Command Center by means of radio and/or cell phone.

## **Preparedness**

In order to maintain this plan, each patient unit will undergo an annual evacuation coinciding with deep cleaning of the unit in order to assess ability of patients to use the stairs.

## **Alternate Care Sites**

**Partial/Short-term:** Patients would be evacuated to the multi-purpose rooms: W-250, W-258, C-416, C-516, and W-630. (C-516 is contingent with Community Hospital East's EOP)

**Full/Long-term:** In cooperation with DMHA, FSSA, Marion County, and State emergency management officials, patients would be evacuated to one of the other State Psychiatric Hospital in Richmond, Logansport, Madison, or Evansville.

## **Evacuation Equipment**

The hospital will maintain a supply of evacuation devices to be located on the units. Nursing Education will maintain an accurate distribution of the devices. Unit Directors are responsible to notify Nursing Education of any admissions or discharges that would affect the distribution of devices. Devices will also be available to any staff that cannot use the stairs.

## **Training**

All staff receive awareness level training on the use of evacuation sleds at orientation. All unit staff will receive annual, documented operational level training.

## ***Traffic and Security Annex***

- All staff and volunteer traffic will go through CHE and park in the parking garage. They will then report to designated units or report to conference room C or designated area and wait for further instructions.
- All incoming supplies will go to the CHE/NDI shared dock.
- Front parking lot will be used for patient/family support center and incident command

# Workplace Violence Annex

## Scope

This plan covers all patients, staff, and visitors to NDI. It covers all workplace violence including civil unrest, active shooter, and any other internal or external threats.

## Purpose

The purpose of this policy is to provide guidance in the event of a threat to the safety of our patients or staff. This policy will set forth the conditions and procedures for locking down the hospital in the event of an internal or external threat.

## Objectives

This plan will accomplish its purpose by:

- Presenting an analysis of the facility vulnerabilities.
- Noting mitigation efforts.
- Outlining response procedures.
- Outlining recovery procedures.
- Noting preparedness efforts.
- Outlining evaluation procedures

## Definitions:

A. *Level 3 Lockdown (Controlled)*: Conditions are judged to require screening of all persons entering and/or exiting the facility and/or grounds; internal hospital operations would continue.

B. *Level 2 Lockdown (Partial)*: Conditions are judged to require no entrance and/or exit of the facility and/or grounds; internal hospital operations would continue.

C. *Level 1 Lockdown (Full)*: Internal or external conditions are judged to exist that require no entrance and/or exit of the facility and/or grounds, no patient movement, and all staff report to a secure, locked location (except for an active shooter in which case, staff are to exit the building per active shooter training).

D. *Active Shooter*: is an individual actively engaged in killing or attempting to kill people in a confined area; in most case, active shooters use firearms and there is no pattern or method to their selection of victims. Active shooter situations are unpredictable and evolve quickly. Because incidents are usually over before law enforcement arrives, individuals must be prepared both mentally and physically to deal with the situation. (Active shooter planning and response, International Association of Emergency Medical Services Chiefs, 2017).

*Run, Hide, Fight*: Active shooter training promoted by the U.S Department of Homeland Security.

## Facility Vulnerabilities

*Demographic:* NDI is a residential hospital that serves acute psychiatric patients. Some patients are committed involuntarily for treatment. Families and friends of some patients are welcome to visit, and some patients are allowed to leave the hospital with responsible party for several hours or weekend visits. It is reasonable to consider that families or friends might become violent over the disposition of their loved-one or be suffering from illness as well. **Additionally, current HVA indicates high probability of civil unrest in which this annex serves to address as well.**

*Staff:* Caring for and treating people with severe mental illness is a very stressful and demanding career. Staff may be verbally or physically accosted in the course of a workday. It is reasonable to consider staff member becoming agitated to violence as a result of stress or conflict with a co-worker or supervisor. In addition, staff members have been terminated from time to time for failure to adhere to hospital policies. It is reasonable to consider a violent threat from a disgruntled former employee. Finally, employees of the hospital, may become engaged in unhealthy relationships. It is reasonable to consider that spouses or partners could bring violence to the workplace or surrounding grounds.

## Mitigation Efforts

*General:* The hospital employ contract unarmed personnel under the supervision of a security Director. There is no emergency department or unsecured public entrances. Restrooms and office doors have locking mechanisms upon closure. Outside entrances require badge reader access or keys.

*Main Entrance:* An ADA door opens automatically to a secured area where the front security can talk with visitor about the reasoning for their visit prior to letting them into the main lobby.

*Patient Units:* All patient units require keys or badge reader access to enter.

*Dock Area:* The dock entrance is located on CHE side of the building and there is secured door with badge reader access that prevent visitors or outsiders from penetrating the building.

## Response Procedures and Responsibilities

1. The Superintendent, Assistant Superintendent, Safety Officer, Security Director, Incident Commander or their designee has the authority to order any level of lockdown for the hospital building or its grounds.
2. An overhead page and/or Vocera will be made to make mass notification using one of the levels described in the definitions.
3. Following notification every staff member will take the action appropriate to that level and deemed best to ensure their personal safety including Run, Hide, Fight.

**RUN:** If it is safe or possible to do so:

- Get out of the building via the quickest path possible while staying out of sight of the perpetrator

Tell others to flee with you but do not spend time trying to convince them. If you feel that it is safest to flee and they feel otherwise, don't argue, and just escape.

- When fleeing, use cover as much as possible.
- Try to be silent when fleeing.
- Get out of line of sight of the windows once outside.
- Once you have reached safety, call 911 immediately. Inform them of the Active Shooter presence.

**HIDE:**

- If it is unsafe to RUN, quickly find a location to HIDE.
- Try to locate a room without windows (or blinds that can be closed) and a door that can lock.
- Turn off the lights if possible.
- Get behind or under large, heavy furniture.
- Silence all mobile devices.
- Remain silent. Talking or loud noises could draw the attention of the perpetrator.
- Only if safe to do so: quietly call 911 to notify them of the active shooter presence.
- Only law enforcement officers will give the all-clear in an active shooter situation. Only emerge if you believe the person giving the instruction to do so is with law enforcement.
- Some employees may choose other hiding places, such as under their desk at their workstation. Of primary importance is to be out of the perpetrator's line of sight.

**FIGHT:**

- If it is unsafe to RUN or HIDE, you should FIGHT.
- If you have decided to FIGHT, you need to commit to the action and be prepared to do whatever it takes to save your own life.
- In these situations, the assailant is likely armed in some manner. In order to best ensure your own safety, you should utilize a force multiplier or weapon of some kind.
- Whenever possible, implement the element of surprise.
- Do whatever is necessary to overpower and subdue the perpetrator.

4. All housekeeping, maintenance, and security personnel will report to designated area for instructions.
5. All maintenance personnel will activate the Emergency Traffic and Security Plan.
6. IT Director or designee will de-activate card readers.
7. Staff will maintain lockdown posture until an all-clear notification. The purpose of this policy is to provide guidance in the event of a threat to the safety of our patients or staff.

8. Notification of a lockdown may be followed by a Code White Alert, Advisory, or Activation of the Emergency Operations Plan.
9. Screening of facility entrance/exits and/or grounds includes any or all of the following:
  - Hospital identification badge
  - Personal identification
  - Bags and packages
  - Equipment and supplies
  - Vehicles
  - questioning of individuals as to destination, etc.

**Sample hazards and activation levels: (Level 1 – highest; Level 3 – Lowest)**

Hazard	Level 3	Level 2	Level 1
Activation of hospital Incident Command	X		
Power Failure	X		
External natural or man-made disaster		X	
Fire – Code Red	X		
Bomb Threat – Code Yellow			X
External Active Shooter		X	
Internal Active Shooter			X*
Patient AWOL/Abduction			X

\*Staff is to exit the facility

**Recovery Procedures**

1. Security will announce an all clear as directed by the incident commander.
2. Incident commander will notify DMHA of the incident and follow directions on steps to maintain the safety and continued treatment of patients.
3. Security section chief will meet with law enforcement when they arrive.

**Preparedness Efforts**

Staff development and nursing education will provide training on preparedness and response to new and current employees in the following ways:

- New Employee Orientation.
- Annual Required Training.
- Periodic drills, tabletop, functional, and full-scale exercises.

**Plan Evaluation**

This plan is an annex to the hospital emergency operation plan and is subject to annual review and revision by the emergency management committee and safety committee. The plan will also be evaluated after a drill or exercise with an after-action report and improvement plan is identified.

## ***Pharmacy Department Emergency Annex***

### **Emergency Situations:**

If large numbers of patient medications are destroyed or damaged on one or more units:

### **During normal Pharmacy Hours:**

Pharmacy staff will replace all stock. Minimum number of medications would be given to ensure filling of all orders. Pharmacy will work with Drug Distributor to order medication. Other local hospitals would be contacted in urgent situations:

Community Hospital East 317-355-5870

Eskenazi 317-880-0000

IU 317-274-7056

VA 317-630-6326

Methodist 317-929-5487

### **After normal Pharmacy Hours:**

The backup MedSelect would be utilized as much as possible, and the on-call pharmacist should be called. Pharmacy Director will direct the next step of actions.

### **If Pharmacy is damaged or destroyed:**

Pharmacy wholesaler would be contacted. Also, may contact area hospitals. The State Board of Pharmacy will be contacted to approve any temporary facility and for legal guidance.

### **If patients are relocated within the hospital:**

MedSelect will be transported and combined as needed by the Pharmacy Department. See below for MedSelect operations both offline and without power.

### **If patients are relocated to another SPH:**

The Pharmacy will work with the State psychiatric hospital to transport medications to the receiving State psychiatric hospital. NDI Pharmacy staff will relocate as possible to the receiving State psychiatric hospital to assist with order entry and patient medication dispensing.

## **MedSelect® DT Complete Power Failure - Emergency Downtime Procedures**

Each MedSelect dispensing terminal (DT) is connected to the facility's backup generator. In addition, each dispensing terminal is equipped with an onboard auxiliary battery power system that can provide limited emergency power to the unit. In the event that both systems fail, emergency downtime procedures will be in effect.

1. If the MedSelect DT is running on auxiliary battery power, log off the unit and call pharmacy.
2. The pharmacy will determine if preparing for manual operation is necessary.
3. If it is determined that manual operation is necessary, a pharmacy staff member will open access to the DT drawers for medications to be dispensed.
4. Keys to each MedSelect DT unit are maintained by the pharmacy only.

## Emergency Decontamination Annex

### Hazard

One of the hazards identified in the hospital Hazards Vulnerability Assessment is a hazardous material release or spill. This hazard is not considered very likely, but it would seem prudent to plan for such an event.

### Capability

NDI will establish and maintain a light hazardous materials decontamination capability. This capability will consist of the following:

1. Designated decontamination area.
2. Decontamination equipment such as light PPE and appropriate soap.

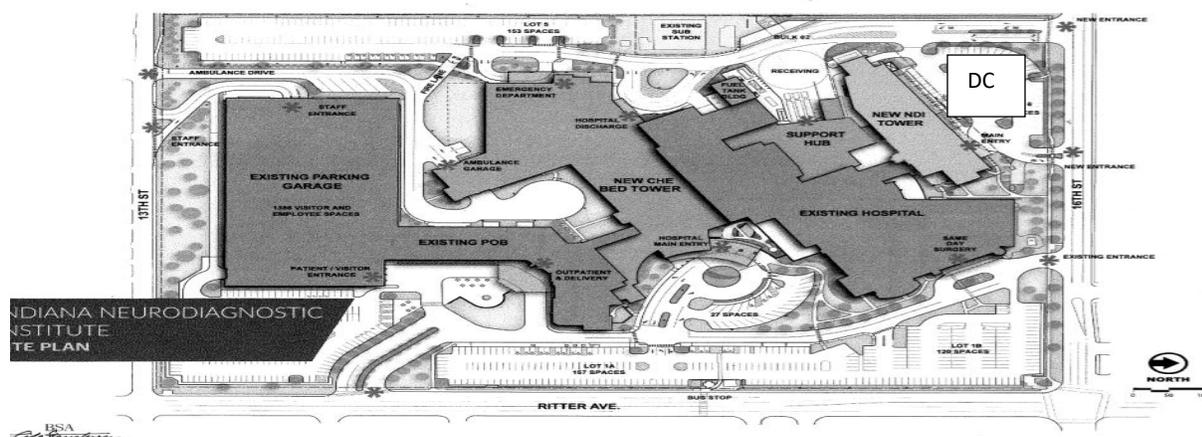
### Designated Location

The designated hazardous materials decontamination area is located on the Lower-level basement and on the Penthouse. First responders will be notified to enter the front parking lot and park near the Sally-port. Individuals with chemical injuries will be treated in the Sally-port before transport.

In the event of any hazardous materials leak or spill, NDI employees will call the Indianapolis Fire Department via Vocera or extension 4500 (Security) which will dispatch an ambulance and fire equipment with firefighters that possess specialized training in this area. The fire department (Station 20) is less than a mile from the NDI building.

The Physical Plant/Maintenance Director will be responsible for the acquisition and maintenance of equipment for this capability. The physical plant Director will be responsible for the training and annual drill necessary for the maintenance of this capability.

## Designated Hazardous Materials Decontamination Areas



## ***Bomb Threat Annex***

### **Purpose**

To establish policy and procedures concerning the receipt of a bomb threat, subsequent and related investigation.

### **POLICY**

All bomb threat investigations, searches and related activities will be carried out with a maximum of discretion so that patients, visitors, and employees are not harmed or unduly alarmed.

In the event a bomb is exploded in the hospital, emergency and investigative assistance will be obtained from local and State agencies, as necessary.

### **PROCEDURES**

Any individual receiving a bomb threat directly or by telephone should obtain all possible information concerning the threat, location of the bomb, time set to go off, what it looks like, what kind of bomb, and identity of the caller (see following *Bomb Threat Call Checklist*). Upon the receipt of a Bomb threat all information will immediately be brought to the attention of the physical plant Director.

- A. The physical plant Director will ensure notifications are made in accordance with this policy.
- B. Upon receipt of information that a bomb threat has been received, the security director or the physical plant Director will interview the person receiving the threat, complete a Threat Record, Attachment A and make emergency notification.
- C. The Superintendent may initiate a disaster response that may include notification of services, search, partial or total evacuation, or contact with outside agencies for assistance.
- D. If a specific location is given, the physical plant Director will:
  1. Assign a security personnel to prevent anyone from moving or touching the suspected bomb.
  2. Contact Indiana State Police and give specific details, Indianapolis Fire Department, and the Bomb Squad.
  3. All persons will be removed from the immediate area; this will include the floors below and above the suspected item.
- E. If no location is given, physical plant personnel will begin an immediate search of exterior areas and public areas such as lobbies, toilets, stairwells, Canteen, Chapel, etc.
- F. All Services will be contacted and requested to search their work areas and report results to Safety Services.
- G. No employee will touch or attempt to disarm a bomb. If a bomb or suspected object is located, the physical plant Director will be notified immediately.

- H. The physical plant Director will record the locations of areas searched and results of the search will be reported to the supervisor immediately.
- I. The physical plant Director will make all notifications and record information in their Daily Journal.
- J. Consideration will be given to limiting access to the hospital area and implementation of the package inspection procedure if necessary. Levels of access and exit will include normal access to full closure.

## **BOMB THREAT CALL CHECKLIST**

**1. Exact wording of threat:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. Are there any distinguishing back ground noises?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Questions to ask. Response and repeat in sequence.** When will the bomb explode? \_\_\_\_\_  
\_\_\_\_\_

Where is the bomb? \_\_\_\_\_  
\_\_\_\_\_

What building is it in? \_\_\_\_\_  
\_\_\_\_\_

What floor is it on?

Can we help you?

**4. Caller's voice and manner description:**

Calm	<input type="checkbox"/>	Laughing	<input type="checkbox"/>	Raspy	<input type="checkbox"/>
Angry	<input type="checkbox"/>	Sobbing	<input type="checkbox"/>	Deep	<input type="checkbox"/>
Excited	<input type="checkbox"/>	Distinct	<input type="checkbox"/>	Cracking	<input type="checkbox"/>
Slow	<input type="checkbox"/>	Slurred	<input type="checkbox"/>	Accent	<input type="checkbox"/>
Rapid	<input type="checkbox"/>	Nasal	<input type="checkbox"/>	Disguised	<input type="checkbox"/>
				Male	<input type="checkbox"/>
				Female	<input type="checkbox"/>
				*Familiar	<input type="checkbox"/>

**5. \*If familiar, who did the caller sound like?** \_\_\_\_\_

**6. Date and Time call received:** Date: \_\_\_\_\_ Time: \_\_\_\_\_

**7. Receiver's name:** Name: \_\_\_\_\_

## ***Winter Storm Emergency Annex***

### **Purpose**

This annex guides the hospital's response to a winter storm emergency. This policy applies to all state and contract employees.

A winter storm (ice, sleet, large amounts of snow and wind) is a likely occurrence in Central Indiana. A winter storm is unique in the following ways:

- a. Hours or days of advanced notice.
- b. Storm paths and accumulation amounts are unpredictable.
- c. Could last several days.
- d. Little danger of property damage, injury, or loss of life.
- e. Not necessary to stand up the Hospital Incident Management Team.
- f. Normal hospital operations could be disrupted especially regarding a lack of staff.
- g. Supplies from outside vendors may be interrupted or delayed.

### **Essential Staff**

#### **Direct Care Staff (Nurses and Special Attendants) *On Duty*:**

- All direct care staff are required to remain at their posts as a winter storm approaches or begins.
- No direct care staff will be allowed to leave early except by permission of their supervisor.
- Direct care staff may be held on duty until a replacement arrives.
- Failure to remain will be considered job abandonment subject to discipline up to termination.
- All direct care staff are urged to make personal preparedness plans necessary in order to remain at their posts. This includes child, elder or pet care.

#### **Direct Care Staff *Off Duty*:**

- All shifts will report as scheduled
- Direct care staff who are scheduled but unable to report because of the weather, must contact the hospital no less than 2 hours before their assigned shift so that a replacement may be located.
- Staff unable to report may be authorized the use vacation, sick, or personal time so as to maintain income.
- Incidents involving staff that fail to report or fail to notify will be referred to Human Resources for appropriate disciplinary action.
- Those who are not scheduled but would like to report may call the hospital.

## **Maintenance/Environmental Services/Security**

- On Duty: Expected to remain at the discretion of their supervisor.
- Off Duty: Expected to report at the discretion of their supervisor.

## **All Other Staff:**

- Remain or report at the discretion of their supervisor.

## **Notification**

- Superintendent or designee will declare a Code White Winter Emergency at his/her discretion.
- Superintendent or designee will notify the Emergency Management Director by telephone of the level of activation:

**Advisory** – The potential for a Winter Storm Emergency activation exists.

**Alert** – A Winter Storm Emergency activation is likely; prepare to notify hospital leadership via e-mail, text, or phone.

**Activation** – Notify hospital leadership of a Code White Winter Storm Emergency via e-mail, text, or phone; Superintendent or designee may stand up the Hospital Incident Management Team. Emergency Management Director will notify all state direct care employee via when-to-work.

## **Essential Services**

- The hospital will maintain staff sufficient for the basic care and safety of the patients.
- Patient groups and activities will operate on a discretionary basis subject to staff availability.
- Staff may be assigned to different functions as needed.

## **Staff Support**

- Shelter/Food: The hospital will provide food and sleeping arrangements for staff who are unable to return home due to inclement weather. The multi-purpose rooms, conference room (A, B, and or C) or a vacant unit will be designated and equipped for staff sleeping.
- Time: All staff will report to designated areas as assigned by supervisors.

## **Demobilization**

The Superintendent or designee will determine at what point to return the hospital to normal operations. The Emergency Management Director will notify on duty staff via Vocera,

overhead page and off duty staff via e-mail, text, or phone.

## Emergency Conditions and Leave Policy



### **EMERGENCY CONDITIONS**

The state personnel director may authorize the closing of a state facility or the curtailing of operations due to emergency conditions. Weather conditions affecting only the ability to commute will not be considered emergency conditions.

When a state facility is closed due to emergency conditions, affected employees may be reassigned to other locations. Each affected employee who cannot be reassigned, or was not on other leave, shall be given leave with pay. Employees required to work at the affected work location during the emergency shall be granted compensatory time on an hour-for-hour basis in addition to payment of wages.

If conditions of a serious nature exist, but are not sufficient to close facilities or cease operations, the appointing authority may authorize leave without pay for affected employees. Employees may elect to use vacation leave, personal leave or compensatory time off to cover their absence.

The emergency conditions provisions for paid leave or compensatory time shall not apply to employees on sick leave or any other prior-approved leave nor to any other employees who are engaged in emergency response activities, such as, but not limited to snow removal, radio operations or emergency management.

## ***Pandemic Infectious Disease Annex***

### **PURPOSE:**

The purpose of the NDI Pandemic Infectious Disease Plan is to ensure advanced planning and preparedness to help mitigate the impact associated before, during, and after a pandemic arrives. Planning prior to an outbreak may help reduce spread of the disease, decrease the number of cases and death, and ensure the maintenance of essential hospital care. This Annex is part of the hospital Emergency Operations Plan (EOP).

### **SCOPE:**

The plan addresses preparedness, mitigation, and response activities to be taken by NDI staff during the following four pandemic stages: Pre-pandemic, Pandemic Alert, Pandemic, and Post-Pandemic. For each stage, the plan identifies the following functions:

- Surveillance
- Communication
- Surge
- Employee Health and Housing
- Medications
- Post-Mortem

This plan is limited to an infectious disease pandemic. A pandemic is the world-wide spread of a new disease as opposed to a localized/seasonal outbreak or epidemic (W.H.O.). The likelihood of a disease pandemic has been accelerated by inexpensive, rapid and global transportation. This exposes many more people to what formerly were localized outbreaks from customs that bring humans into contact with wild and domesticated animals. This plan is not intended to respond to a localized disease outbreak such as seasonal influenza. Efforts are ongoing by NDI staff to limit the exposure to staff and patients from seasonal influenza viruses through annual

### **PLAN AUTHORITY**

The Infectious Disease Pandemic Plan is approved annually by the Infection Prevention Committee consisting of the following:

- Infection Preventionist
- Medical Staff
- Director of Nursing
- Employee Health Nurse/Clinic Coordinator
- Quality Assurance

- Pharmacy
- Environmental Services
- Food Services
- Staff Development/Nursing Education

This plan was reviewed and approved by the NDI Infection Prevention Committee in March of 2021.

This plan was reviewed and approved by the NDI Emergency Management Committee in February 2021.

## **PLAN EVALUATION AND REVISION**

This plan is evaluated by the Infection Prevention Committee and included in the hospital *Multi-year Training and Exercise Program*. Revisions to the plan will be made by the Hospital Emergency Coordinator and the Infection Preventionist and approved by the Infection Prevention Committee.

## **PLAN ACTIVATION**

This plan will be activated based on the four Pandemic Periods issued by the W.H.O.: Pre-Pandemic, Pandemic Alert, Pandemic, and Post-Pandemic (see below). This scale is also used by the State of Indiana Pandemic Influenza Operations Plan.

## **DEFINITIONS**

*Pandemic:* A world-wide epidemic.

*Epidemic:* An epidemic is a marked rise in disease in a region affecting a localized population, while a pandemic refers to a disease outbreak that is worldwide and affects global populations. An epidemic is not worldwide. For example, malaria can reach epidemic levels in regions of Africa but is not a threat globally.

*Emergency Operations Plan (EOP):* The plan that guides an organization's response to a disaster. An EOP consists of a Base Plan, Annexes, and Appendices.

*Tabletop Exercise (TTX):* A discussion-based exercise where participants evaluate a plan against a realistic scenario.

*Droplet Precautions:* A form of precaution to apply to patients known or suspected to be infected with a pathogen that can be transmitted by droplet route. See Attachment B for policy on droplet precautions.

*Seasonal Influenza:* Influenza that occurs around the world every year, usually in the winter.

*Pandemic Influenza:* A serious form of influenza caused by a novel virus which has not been experienced by currently living humans. It easily spreads from human to human primarily by large droplets from talking, sneezing, and coughing. Severity varies from year to year, but is milder than a pandemic because humans have some immunity to seasonal influenza, but not to pandemic influenza.

*W.H.O.:* World Health Organization

*C.D.C.:* Centers for Disease Control

*Strategic National Stockpile (SNS):* CDC's Strategic National Stockpile is the nation's largest supply of potentially life-saving pharmaceuticals and medical supplies for use in a public health emergency severe enough to cause local supplies to run out.

*Isolation:* Separating ill individuals from those not ill to help prevent transmission of disease.

*F.E.M.A.:* Federal Emergency Management Agency. An agency of the U.S. Department of Homeland Security tasked with the preparedness, response, mitigation, and recovery of disasters.

*Hazard Vulnerability Analysis (HVA):* An annual consideration by an organization to forecast threats based on environmental, demographic, and historical data; required by The Joint Commission and CMS.

*Critical Incident Stress Management (CISM):* Specialized training that equips staff to conduct sessions with staff who might have been traumatized by the death or serious injury of a patient or colleague or participated in a disaster such as a disease pandemic.

*Indiana Health Alert Network (IHAN):* Mass notification system intended to distribute health alerts to healthcare providers and public health professionals across the state of Indiana.

A note on plan triggers:

There exist some discrepancies about the different phases of the pandemic process. The WHO phases: the U.S. Government (USG) uses stages, and the CDC uses intervals.

## **Influenza**

Level I: No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk to humans is considered low.

Level II: No new influenza virus subtypes have been detected in humans. However, an influenza virus subtype circulating in animals poses a substantial risk to humans.

### **Surveillance Activities**

- Y Train on the plan so that staff are knowledgeable about their role
- Y Exercise the plan to discover gaps
- Y Review and revise plan annually or as needed after an exercise
- Y Infection Preventionist should be actively monitoring sources such as:
  - Indiana Department of Health
  - Marion County Department of Health
  - MESH
  - CDC
  - WHO
  - APIC
  - IHAN
- Y Plan to review and revise this plan annually.
- Y Collaborate with the Hospital Emergency Coordinator to include pandemic infectious disease in the Multi-year Training and Exercise Program
- Y Review for accuracy the Surveillance portion of the Pandemic Period of this plan
- Y Stockpile personal protective equipment including N95 masks, gloves, face shields, hand sanitizer, antimicrobial soap, and tissues
- Y Consider obtaining an MOU to be able to obtain testing supplies
- Y Check supply expiration: discard and replace

### **Communications Activities**

- Y Build awareness among staff and patients about this plan as well as infectious disease pandemics with educational materials and hospital newsletter articles
- Y Attend emergency preparedness/infection prevention seminars and workshops; communicate salient points
- Y Collaborate with Staff Development to create training modules
- Y Attend District 5 Healthcare Coalition meetings to become familiar with colleagues and the coalition's mass notification system

- Y Test all emergency contact numbers

### **Surge Activities**

- Y Update contact numbers with Infection Preventionist at the other state hospitals
- Y Collaborate with the Hospital Emergency Coordinator to include surge from other SPHs in a surge exercise
- Y Be familiar with the Evacuation Annex in the hospital EOP
- Y Review for accuracy the Surge portion of the Pandemic Period of this plan

### **Employee Health/Housing Activities**

- Y Review/revise and exercise the Employee Health/Housing portion of the Pandemic Period of this plan
- Y Participate in planning meetings and exercises involving the screening of staff and patients, preparation for staff shortages, and general staff personal preparedness
- Y Prepare inventories of supplies needed by staff who become ill or are needed to remain at the hospital such as:
  - Cots and pillows
  - Linens, blankets, sheets and towels
  - Personal and feminine hygiene supplies
  - Snacks/water
- Y Review/revise/exercise plans to set up alternate staff care and housing within the hospital in collaboration with the Hospital Emergency Coordinator

### **Medications Activities**

- Y Review/revise/exercise the acquisition, distribution, and tracking of medications
- Y Review the status of the MOU with the Indiana Department of Health (see attached)

### **Post-Mortem Activities**

- Y Review/revise/exercise the plan in the event of fatalities
- Y Review the status of any MOUs and/or procedures concerning the disposition of the deceased

- Υ Review/revise/exercise on-the-job training that may be needed concerning the disposition of the deceased
- Υ Obtain and inventory supplies and forms necessary for the proper handling of the deceased

## CASE DETECTION/MANAGEMENT DURING INTER-PANDEMIC AND PANDEMIC ALERT PERIODS

*Situation: No human cases of pandemic infectious disease are present in the community. Human cases might be present in another country or region of the United States.*

**Clinical Criteria:** Illness with temperature > 38 C and...

- Cough, sore throat or dyspnea and
- Requiring hospitalization or non-hospitalization with epidemiological link

***If no to any, treat as clinically indicated, but recalculate if suspicious***

**AND**

**Epidemiologic Criteria:** Ask patient about the following within 10 days of symptom onset...

- History of recent travel to an affected area and at least 1 of the following:
  - Direct contact with poultry or poultry products (influenza) or,
  - Close contact with a person with suspected or confirmed disease or,
  - Close contact with a person who died or was hospitalized with the illness
- Employment in an occupation at particular risk.

**IF YES TO EITHER:**

- Initiate Standard and Droplet Precautions
- Treat as clinically infected
- Notify state or local health department
- Initiate clinical workup as clinically indicated
- Collect and send specimens for testing to Indiana State Department of Health or CDC (Contact Marion County Health Department for the most current guidelines)
- Begin empiric anti-viral treatment
- Help identify contacts including healthcare workers

If **novel influenza** (+) by culture or RT-PCR:

- Continue Standard and Droplet Precautions
- Continue antivirals
- **Do not cohort with seasonal influenza patients**
- Treat complications such as secondary bacterial pneumonia as indicated
- Provide updates to health department

For **influenza** testing (-):

- Continue infection control precautions
- Treat complications as indicated

If **seasonal influenza** (+):

- Continue Standard and Droplet Precautions
- Continue antivirals for minimum of 5 days
- Treat complications as indicated

SarsCoronaVirus2 was declared a worldwide pandemic in March of 2020.

### **Clinical Criteria-SarsCoronaVirus2**

At least two of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s)

**OR**

At least one of the following symptoms: cough, shortness of breath, or difficulty breathing

**OR**

Severe respiratory illness with at least one of the following:

- Clinical or radiographic evidence of pneumonia, **OR**
- Acute respiratory distress syndrome (ARDS).

**AND**

No alternative more likely diagnosis

### **Laboratory Criteria**

Laboratory evidence using a method approved or authorized by the U.S. Food and Drug Administration (FDA) or designated authority:

*Confirmatory laboratory evidence:*

- Detection of severe acute respiratory syndrome coronavirus 2 ribonucleic acid (SARS-CoV-2 RNA) in a clinical specimen using a molecular amplification detection test

*Presumptive laboratory evidence:*

- Detection of specific antigen in a clinical specimen
- Detection of specific antibody in serum, plasma, or whole blood indicative of a new or recent infection\*

*\*Serologic methods for diagnosis are currently being defined.*

## Epidemiologic Linkage

One or more of the following exposures in the 14 days before onset of symptoms:

- Close contact\*\* with a confirmed or probable case of COVID-19 disease; **OR**
- Close contact\*\* with a person with:
  - clinically compatible illness **AND**
  - linkage to a confirmed case of COVID-19 disease.
- Travel to or residence in an area with sustained, ongoing community transmission of SARS-CoV-2.
- Member of a risk cohort as defined by public health authorities during an outbreak.

*\*\*Close contact is defined as being within 6 feet for at least a period of 10 minutes to 30 minutes or more depending upon the exposure. In healthcare settings, this may be defined as exposures of greater than a few minutes or more. Data are insufficient to precisely define the duration of exposure that constitutes prolonged exposure and thus a close contact.*

### Criteria to Distinguish a New Case from an Existing Case

Not applicable (N/A) until more virologic data are available.

### Case Classification

#### Probable

- Meets clinical criteria **AND** epidemiologic evidence with no confirmatory laboratory testing performed for COVID-19.
- Meets presumptive laboratory evidence **AND** either clinical criteria **OR** epidemiologic evidence.
- Meets vital records criteria with no confirmatory laboratory testing performed for COVID-19.

#### Confirmed

- Meets confirmatory laboratory evidence.

## **PANDEMIC ALERT PERIOD**

The Alert Period would be a time to shift from routine preparedness to leaning forward toward preparation for a possible response in the near future.

### **Influenza**

Level III: Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread, or at most rare instances of spread to a close contact.

Level IV: Human infection(s) with a new subtype, but no human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.

Level V: Larger cluster(s) but human-to-human spread is still localized suggesting that the virus is becoming increasingly better adapted to humans but may not yet be fully transmissible – substantial pandemic risk.

### **Surveillance Activities**

- Υ IP and Hospital Emergency Coordinator will review Pandemic Period plan for possible implementation
- Υ Infection Prevention (IP) will increase updates from sources to weekly
- Υ IP will devise a plan for the screening of staff/patients who have recently travelled to infected areas. This would involve sending screening forms to Service Line Managers and Unit Directors
- Υ IP will check inventory of testing supplies and review testing procedures, training others to administer/document testing
- Υ IP devises a plan to screen staff upon arrival to work
- Υ IP will alert professional staff to the need for increased awareness of symptoms
- Υ IP will instruct all managers, supervisors, and nursing staffing coordinator to monitor employee call-ins for symptoms and equip with a form to standardize data

### **Communications Activities**

- Υ IP will inform Infection Prevention Committee and HIMT Command Staff of the change in status
- Υ IP will implement a plan to educate and update staff periodically
- Υ IP will post flyers to educate staff and patients on respiratory hygiene and coughing etiquette
- Υ IP will prepare a plan for cross-training of staff in the event of a full pandemic

- Υ IP will coordinate with Staff Development to develop a modified NEO that includes Infection Prevention, Emergency Management, Confidentiality, and orientation to areas/units.

### **Surge Activities**

- Υ IP and the Hospital Emergency Coordinator will discuss:
  - The possibility of receiving patients from another SPH in the event of a pandemic.
  - A list of functions that can be delayed; essential staff; non-essential staff that could be Reassigned and minimum staffing.
  - Three alternate locations for patient surge.
  - The maintenance of food, utilities, and medical supplies.
  - The procedures for rapidly obtaining state licensure information.

### **Employee Health/Housing Activities**

- Υ IP and the Hospital Emergency Coordinator will discuss:
  - Housing options for employees.
  - Mobilization of the CISM team.
  - Communication of staff personal preparedness materials.
  - Communication of staff educational materials.

### **Medications Activities**

- Υ IP with the Hospital Emergency Coordinator

### **Post-Mortem Activities**

- Υ IP will review the attached *General Guidelines for Handling the Deceased*.
- Υ IP will review inventory of supplies and forms necessary for the proper handling of the deceased along with any staff training materials needed.
- Υ IP and the Hospital Emergency Coordinator will review possible morgue locations in the hospital.

## **PANDEMIC PERIOD**

This phase would require a response by the NDI HIMT under the direction of DMHA, FSSA and in coordination with the CDC, Marion County Health Department, and the Indiana Department of Health.

Pandemic increased with sustained transmission in the general population. Widespread human outbreaks in multiple locations overseas along with the first human contact in North America and spreading throughout the United States (US).

### **Surveillance Activities**

- Υ Maintain a daily monitoring of WHO, CDC, and ISDH sources such as IHAN.
- Υ Institute tracking of:
  - Staff/patients who have been to affected areas.
  - Symptoms of patients and staff.
- Υ Institute testing for possible pandemic infections in the hospital as well as staff who call in sick.
- Υ HIMT will stand up the hospital incident command in order to determine and coordinate the response.

### **Communications Activities**

- Υ Provide regular updates to HIMT, Service Line Managers, and Department Managers to pass on to their staff.
- Υ Provide regular updates to nursing staff prior to the daily clinical report.
- Υ Conduct modified orientations for volunteers, reassigned staff and Licensed Independent Practitioners.

### **Surge Activities**

- Υ IP and HIMT will make preparations if necessary, to receive surge patients (ill or well) from another SPH.
- Υ Nursing Administration and staffing coordinator will determine necessary staffing needs and adjust for the surge period.
- Υ Assess the stock levels of supplies as they diminish.
- Υ Utilize alternative locations for patients according to disease status.
- Υ Establish a list of functions that can be delayed, a list of essential staff, and a list of non-essential staff that could be re-assigned.

### **Employee Health/Housing Activities**

- Υ Amass supplies necessary to accommodate staff who are unable to leave the facility.
- Υ Prepare to supply and house staff and patients in other areas of the hospital.
- Υ Arrange for Critical Incident Stress counselling as well as stress-relieving activities.

### **Supply Shortage**

- Υ Once notified, Storeroom will up their PPE supply levels to 180-day supply vs 90-day typical supply requirements.
- Υ Establish a PAR level for each unit/department regarding PPE supplies, until 180-day supply level has been reached.

### **Medications Activities**

- Υ

### **Post-Mortem Activities**

- Υ Report any fatalities to the Marion County Health Department.
- Υ Follow the *General Guidelines for Handling the Deceased*.
- Υ Use appropriate forms to document.
- Υ Conduct staff training as needed.

## **CASE DETECTION AND CLINICAL MANAGEMENT DURING THE PANDEMIC PERIOD**

*Situation: Pandemic influenza circulating in the community*

Illness **with both** of the following:

- Temperature > 38 C
- Cough, sore throat or dyspnea

YES

NO

- Initiate Standard and Droplet Precautions
- Test for pandemic influenza in a subset of cases

- If no **to either**, treat as clinically indicated
- Re-evaluate if suspicious

YES

Requires hospitalization

NO

- Admit to cohort or single room
- Initiate work-up as clinically indicated
- Treat complications
- Follow current antiviral treatment strategies
- Notify Health Department

- Hospitalize if worsens
- Give instructions for home care
- Follow antiviral strategies
- Provide other therapies

## **POST-PANDEMIC PERIOD**

This phase would require a response by the NDI HIMT under the direction of DMHA, FSSA and in coordination with the CDC, Marion County Health Department, and the Indiana Department of Health.

### **Surveillance Activities**

- Υ Return surveillance to pre-pandemic level.
- Υ Participate in the HIMT after Action Review of the incident.
- Υ Replenish supplies such as test kits and forms.

### **Communications Activities**

- Υ Collaborate with the HIMT per their demobilization process.
- Υ Participate in the HIMT after Action Review of the effectiveness of communications during the incident.
- Υ Submit all relevant paperwork with the Planning Section Chief of the HIMT.

### **Surge Activities**

- Υ Participate in the HIMT after Action Review of the effectiveness of patient surge.
- Υ Return areas occupied by surge patients to former condition and use.
- Υ Replenish supplies.

### **Employee Health/Housing Activities**

- Υ Participate in the HIMT after Action Review of the effectiveness of employee health/housing measures.
- Υ Return areas occupied by staff to former condition and use.
- Υ Replenish supplies and forms.

### **Medications Activities**

- Υ Participate in the HIMT after Action Review

### **Post-Mortem Activities**

- Υ Return areas used for post-mortem activities to former use.

- Υ Participate in the HIMT after Action Review of any post-mortem measures taken.
- Υ Replenish supplies and forms.
- Υ Maintain PPE supplies for Contact Droplet Precautions
- Υ Implement and maintain N95 Fit testing for all employees with patient contact.

## **ATTACHED DOCUMENTS**

1. *General Guidelines for Handling the Deceased*
2. *Daily Employee Screening Form*
3. *Patient Line Listing Tool*
4. *Employee Line Listing Tool*
5. *Isolation Precaution Standards (Standard and Droplet) and Respiratory Hygiene/Cough Etiquette*

### **GENERAL GUIDELINES FOR HANDLING THE DECEASED**

- Use Standard Precautions when in contact with blood or body fluids, including good hand washing.
- Routinely wear single layer gloves and a surgical/procedure mask.
- Prior to handling a body, place a mask over the mouth/nose of the deceased to prevent inhalation of residual air that might be expelled from the lungs when the body is moved. Remove mask before closing shroud.
- If risk of splash or spray, wear a protective gown and eye/face barrier.
- Do not eat, smoke or drink when handling a body.
- Avoid wiping your eyes, mouth or nose with your hands.
- Remove all personal protective equipment after handling body and wash hands thoroughly. Decontaminate all surfaces and any equipment used to transport body.
- Keep movement of the head to a minimum.
- Do not spray or place disinfectant on the body.
- Do not write identifiers on the body or on the body bag as they may erase. Use proper labeling on the inside and outside of the shroud.
- Handle body carefully.
- Lay bodies in one layer only.
- Track all morgue admissions and releases.
- Refrigerate between 34 and 42 F.
- Cultural and religious practices should be respected.

### DAILY EMPLOYEE SCREENING

Fitness for work: Temp < 100; no cough or sore throat

Time In	Time Out	Name	Unit/ Dept.	Temp	Cough Y/N	Sore Throat Y/N	Fitness for Work Y/N	Further Action <small>Denied shift/ sent home</small>	

**PATIENT LINE LISTING TOOL**

Date: \_\_\_\_\_

Illness Outcomes	Expired (Date)							
	Hospitalized							
	To ER for evaluation							
	S. Pneumonia Positive							
	Influenza Positive							
Antibiotic	Yes/No							
Antivirals	Yes/No							
Pneum. Test Result	Sputum culture +/-, pending, NA							
	Gram Stain +/-, pending, NA							
Influenza Test Result	Viral Culture +/-, pending, NA							
	Rapid antigen test +/-, pending,							
Illness Description	Sore Throat							
	Rhinitis							
	CXR confirmed pneumonia							
	SpO2 < 95%							
	Purulent Sputum							
	Chest Congestion							
	Malaise							
	Cough							
	Tmax							
Vaccinated	#Pneumococcal							
	#Influenza							
	ID No./Unit							
	Patient							

**EMPLOYEE LINE LISTING TOOL**

Date: \_\_\_\_\_

Illness Outcomes	Expired (Date)								
	Hospitalized								
	To ER for evaluation								
	S. Pneumonia Positive								
	Influenza Positive								
Antibiotic	Yes/No								
Antivirals	Yes/No								
Pneum. Test Result	Sputum culture +/-, pending, NA								
	Gram Stain +/-, pending, NA								
Influenza Test Result	Viral Culture +/-, pending, NA								
	Rapid antigen test +/-, pending,								
Illness Description	Sore Throat								
	Rhinitis								
	CXR confirmed pneumonia								
	SpO2 < 95%								
	Purulent Sputum								
	Chest Congestion								
	Malaise								
	Cough								
	Tmax								
Vaccinated	#Pneumococcal								
	#Influenza								
	ID No./Unit								
	Patient								

Isolation Precaution Standards (page 1 of 4)

SUMMARY OF INFECTION CONTROL RECOMMENDATIONS FOR CARE OF PATIENTS WITH PANDEMIC INFLUENZA

Adapted from CDC. SEE [HTTP://WWW.HHS.GOV/PANDEMICFLU/PLAN/PDF/S05.PDF](http://www.hhs.gov/pandemicflu/plan/pdf/s05.pdf)

COMPONENT	RECOMMENDATIONS
<p><b>STANDARD PRECAUTIONS</b></p> <p>See: <a href="http://www.cdc.gov/ncidod/dhgp/gl_isolation_standard.html">http://www.cdc.gov/ncidod/dhgp/gl_isolation_standard.html</a></p>	
<p><b>Hand Hygiene</b></p>	<p>Perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items; before and after removing gloves; and between patient contacts. Hand hygiene includes both handwashing with either plain or antimicrobial soap and water or use of alcohol-based products (gels, rinses, foams) that contain an emollient and do not require the use of water. If hands are visibly soiled or contaminated with respiratory secretions, they should be washed with soap (either non-antimicrobial or antimicrobial) and water. In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbicidal activity, reduced drying of the skin, and convenience.</p>
<p><b>Personal Protective Equipment (PPE)</b> -Gloves, Gowns, Face/eye protection (e.g. surgical or procedure mask and goggles or a face shield), etc.</p>	<p>Gloves-for touching blood, body fluids, secretions, excretions, and contaminated items; for touching mucous membranes and non-intact skin. Gown-during procedure and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated. Face/eye protection-during procedures and patient care activities likely to generate splash or spray of blood, body fluids, secretions, or excretions</p>
<p><b>Safe Work Practices</b></p>	<p>Avoid touching eyes, nose, mouth, or exposed skin with contaminated hands (gloved or ungloved); avoid touching surfaces with contaminated gloves and other PPE that are not directly related to patient care (e.g. door knob, keys)</p>
<p><b>Soiled patient care equipment</b></p>	<p>Handle in a manner that prevents transfer of microorganisms to oneself, others, and environmental surfaces; wear gloves if visibly contaminated; perform hand hygiene after handling equipment.</p>

Isolation Precaution Standards (page 2 of 4)

Standard Precautions Continued

<p><b>Patient resuscitation</b></p>	<p>Avoid unnecessary mouth-to-mouth contact; use mouthpiece, resuscitation bag, or ventilation devices to prevent contact with mouth and oral secretions.</p>
<p><b>Soiled linen and laundry</b></p>	<p>Handle in a manner that prevents transfer of microorganisms to oneself, others, and to environmental surfaces; wear gloves (gown if necessary) when handling and transporting soiled linen and laundry; and perform hand hygiene.</p>
<p><b>Needles and other sharps</b></p>	<p>Use devices with safety features when available; do not recap, bend, break, or hand-manipulate used needles; if recapping is necessary, use one-handed scoop technique; place used sharps in a puncture-resistant container.</p>
<p><b>Environmental cleaning and disinfection</b></p>	<p>Use EPA-registered hospital detergent-disinfectant; follow standard facility procedures for cleaning and disinfection of environmental surfaces; emphasize cleaning/disinfection of frequently touched surfaces (e.g. bed rails, phone, lavatory surfaces).</p>
<p><b>Disposal of solid waster</b></p>	<p>Contain and dispose of solid waste (medical and non-medical) in accordance with facility procedures and/or local or state regulations; wear gloves when handling wastes; wear gloves when handling waste containers; perform hand hygiene.</p>
<p><b>Respiratory hygiene/cough etiquette</b> Source control measures for persons with symptoms of a respiratory infection; implement at first point of encounter (e.g. triage/reception areas) within a healthcare setting.</p>	<p>Cover the mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacles; perform hand hygiene after contact with respiratory secretions; wear a mask (procedure or surgical) if tolerated; sit or stand as far away as possible (more than 3 feet) from persons who are not ill.</p>

Isolation Precaution Standards (page 3 of 4)

<b>DROPLET PRECAUTIONS</b>	
SEE <a href="http://www.cdc.gov/ncibod/dhgp/gl_isolation_standard.html">HTTP://WWW.CDC.GOV/NCIBOD/DHGP/GL ISOLATION STANDARD.HTML</a>	
<b>Patient Placement</b>	Place patients with influenza in a private room or cohort with other patients with influenza. Keep door closed or slightly ajar; maintain room assignments of patients in nursing homes and other residential settings; and apply droplet precautions to all persons in the room.  During early stages of a pandemic, infection with influenza should be laboratory confirmed, if possible.
<b>Personal protective equipment</b>	Wear a surgical or procedure mask for entry into patient room; wear other PPE as recommended for standard precautions.
<b>Patient transport</b>	Limit patient movement outside of room to medically necessary purposes; have patient wear a procedure or surgical mask when outside the room.
<b>Other</b>	Follow standard precautions and facility procedures for handling linen and laundry and dishes and eating utensils, and for cleaning/disinfection of environmental surfaces and patient care equipment, disposal of solid waste, and postmortem care.
<b>AEROSOL-GENERATING PROCEDURES</b>	During procedures that may generate small particles of respiratory secretions (e.g., nebulizer treatment, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and N95 mask.

## RESPIRATORY HYGIENE/COUGH ETIQUETTE

- To contain respiratory secretions, all persons with signs and symptoms of a respiratory infection, regardless of presumed cause, should be instructed to:
  - Cover the nose/mouth when coughing or sneezing
  - Use tissues to contain respiratory secretions
  - Dispose of tissues in the nearest waste receptacle after use
  - Perform hand hygiene after contact with respiratory secretions and contaminated objects/materials.
- Healthcare facilities should ensure the availability of materials for adhering to respiratory hygiene/cough etiquette in waiting areas for patients and visitors:
  - Provide tissues and no-touch receptacles for used tissue disposal
  - Provide conveniently located dispensers of alcohol-based hand rub
  - Provide soap and disposable towels for hand washing where sinks are available.
- During periods of increased respiratory infection in the community, persons who are coughing should be offered either with a procedure mask (i.e. with ear loops) or a surgical mask (i.e. with ties) to contain respiratory secretions.
- Coughing persons should be encouraged to sit as far away as possible (at least 3 feet) from others in common waiting areas.
- Some facilities may wish to institute this recommendation year-round.

## **General Employee Emergency Annex**

### **Introduction**

You may get a call in the night; you may hear about it on the news; you may know about it for days ahead of time – a disaster that hits Indiana, Indianapolis, and NDI.

A **disaster** is an incident that is so large or complex that it overwhelms the normal ability of our staff to cope. Some are man-made and purposeful such as an active shooter or arson fire. Some are accidental such as a hazardous material leak or a fire. Most disasters in Indiana are weather related. These can be sudden such as a tornado or earthquake or slow approaching such as a winter storm or flood.

Whatever form a disaster takes, it is our duty to protect our patients and each other from harm as well as continue to provide the essential care our patients need regardless of the circumstances. Provision of safety, shelter, food, water, and treatment must continue for our patients whether the incident is sudden, purposeful, or slow-moving.

A famous author once wrote that “being prepared is half the victory”, meaning that half of our success in responding quickly and well to a disaster is what we do before the disaster strikes. Prior to a disaster there is the luxury of time. Time, when used properly gives us the advantage of planning. But, with the large variety of possible disasters, how do we plan to respond to them all?

We do not. In the last several years, emergency management researchers have discovered that one plan can cover nearly all disasters. This is called an **all-hazards** approach. This means that there are a great deal of similarities to preparing for and responding to disasters. With one plan, an organization or family can prepare for nearly any eventuality.

### **Organization**

This annex is designed to be used during a disaster or exercise. It is arranged with the most immediately helpful information near the front and the more general information in the back. This handbook ought to be picked up to answer three questions:

1. How can I prepare for an exercise/disaster?
2. Where do I go in an exercise/disaster?
3. What do I do in an exercise/disaster?

*Appendix 5 is the hospital emergency organizational chart. This illustrates all the jobs that need to be done during a disaster. When the Superintendent activates the hospital Emergency Operations Plan, all these boxes will be filled with staff trained to do their assigned job. Employees without specific places on this chart will report to the **Conference Room A or designated location**, which is the Personnel Staging area. There you will check in, be briefed on the incident, and receive your assignment.*

## Employee Disaster Response FAQs

- What types of disasters are most likely to involve NDI?  
*Historically, the most likely events will be weather-related such as winter storm, flood, or tornado. Fire and hazardous materials spill are other likely possibilities.*
- What should I do if I hear in the media that NDI is involved in a disaster?  
*Immediately check your FSSA contact source for information about the incident and what your response should be.*
- What should I do if I hear of a disaster when I am about to come in to work?  
*When you arrive, there will be a different traffic pattern; have your identification ready and report to the conference rooms for further instructions and to check in.*
- What if I am not scheduled to work, but want to help anyway?  
*Check your FSSA contact source for whether volunteers are needed. If they are needed, be sure to report to the conference rooms to sign in and receive an assignment.*
- Who is supposed to report to NDI regardless of the hour?  
*Just those who are on the Command and General Staff. See this Emergency Response Handbook for general information.*
- How will I keep informed about the incident?  
*Check your FSSA contact source for the latest and most reliable information. Beware of media reports as they may report unconfirmed information. The information from your FSSA contact source is the most reliable and comes directly from the hospital leadership.*
- What if I am approached by the media about an incident? FSSA/DMHA policy is that all information to the media is to go through their Communications Office. This is because the agency is supposed to communicate timely and accurate information to the public. They will do the best they can to gather accurate information about the entire incident that no one person will have. Refer all media contacts to the FSSA/DMHA Communications Office or your immediate supervisor.
- Where can I go to learn more about the hospital's emergency plan?  
*The hospital website's Hospital Shared Folders, look under "Emergency Management Resources".*

## Job Action Sheet for General Employees

**Mission:** To continue patient safety and care under disaster conditions.

### Preparedness Activities

Y The number one thing that you can do to be prepared to help the hospital in the event of a disaster is to prepare yourself and your family. Attached are some aids to help you get started.

Y **Sign up for emergency notifications at**

[https://public.govdelivery.com/accounts/INFSSA/subscriber/new?topic\\_id=INFSSA\\_5](https://public.govdelivery.com/accounts/INFSSA/subscriber/new?topic_id=INFSSA_5)

(Note: \_ refers to a space)

Y Be aware of the Pre-activation and Activation phases in this Handbook.

Y Be aware of where to go for reliable information.

Y Take one or more of the following FEMA courses:

- IS 22: *Are You Ready? An In-depth Guide to Citizen Preparedness*

<http://www.training.fema.gov/is/courseoverview.aspx?code=IS-22>

- IS 100HCb: *Introduction to the Incident Command System For Healthcare/Hospitals*

<http://www.training.fema.gov/is/courseoverview.aspx?code=IS-100.HCb>

- IS 200HCa: *Applying ICS to Healthcare Organizations*

<http://www.training.fema.gov/is/courseoverview.aspx?code=IS-200.HCa>

- IS 700a: *National Incident Management System: An Introduction*

<http://www.training.fema.gov/is/courseoverview.aspx?code=IS-700.a>

- IS 317: *Introduction to Community Emergency Response Teams (CERT)*

<http://www.training.fema.gov/is/courseoverview.aspx?code=IS-317>

These courses will give you additional background

- Join a CERT (LCH or Marion County) to get disaster training

<http://www.indy.gov/eGov/City/DPS/DHS/Preparedness/Pages/cert.aspx>

### Response Activities

Y Be aware of the condition of the hospital; monitor media for updates

Y Review this Handbook

Y Refer to your FSSA contact for the most up-to-date and reliable information concerning the hospital

Y Decide whether to report to the hospital as a volunteer (if needed) or wait for your shift; **report to the Auditorium**

Y **Come to the hospital prepared**; bring food, water extra clothing, first aid supplies, tools for yourself – do not come to the hospital needing assistance

## Additional Personal Preparedness

The screenshot shows the FEMA 'Ready' website. At the top left is the 'Ready' logo with the tagline 'Prepare. Plan. Stay Informed...'. Navigation links include 'CONTACT US', 'MORE LANGUAGES', 'PAGE', and 'FEMA.GOV'. A search bar is on the right. Below the navigation is a horizontal menu with six categories: 'BE INFORMED', 'MAKE A PLAN', 'BUILD A KIT', 'GET INVOLVED' (highlighted in green), 'BUSINESS', and 'KIDS'. The main content area is titled 'ARE YOU READY? GUIDE' and 'AN IN-DEPTH GUIDE TO CITIZEN PREPAREDNESS'. It features a sub-header 'Are You Ready? An In-Depth Guide to Citizen Preparedness (IS-22) is FEMA's most comprehensive source...' and a section for 'What is Are You Ready?' with an interactive course link. A sidebar on the left lists various preparedness resources like 'Citizen Corps', 'Youth Preparedness', and 'Be a Preparedness Leader'.

<http://www.ready.gov/are-you-ready-guide>

The screenshot shows the American Red Cross website's 'Plan & Prepare' page. The top navigation bar includes 'WHAT WE DO', 'RED CROSS STORIES', 'NEWS & EVENTS', 'FIND YOUR LOCAL RED CROSS', and 'SHOP THE RED CROSS STORE'. Below this is a secondary navigation bar with 'DONATE FUNDS', 'DONATE BLOOD', 'TRAINING & CERTIFICATION', 'WAYS TO HELP', and 'GET ASSISTANCE'. The main content area features a large banner image of a family and a Red Cross volunteer, with the text 'PREPARE YOUR WORKPLACE' and 'Be Red Cross Ready'. Below the banner are three smaller images representing 'Home and Family', 'School and Students', and 'Workplace and Employees'. The page is titled 'Plan & Prepare' and includes a sidebar with a 'Plan & Prepare' menu.

<http://www.redcross.org/prepare>



## Family Emergency Kit Checklist

<https://www.cdc.gov/ncbddd/hemophilia/documents/familyemergencykitchecklist.pdf>

## ***2021 Continuity of Operations Plan (COOP)***

The 2021 Continuity of Operations Plan (COOP) is located in two locations:

1. L:\Emergency Management Resources\EOP
2. Inside of the Incident Command Binder located in the security front office

## **Plan Appendices**

The following pages contain various appendices such as forms, maps, job aids, and Mutual Aid Agreements.

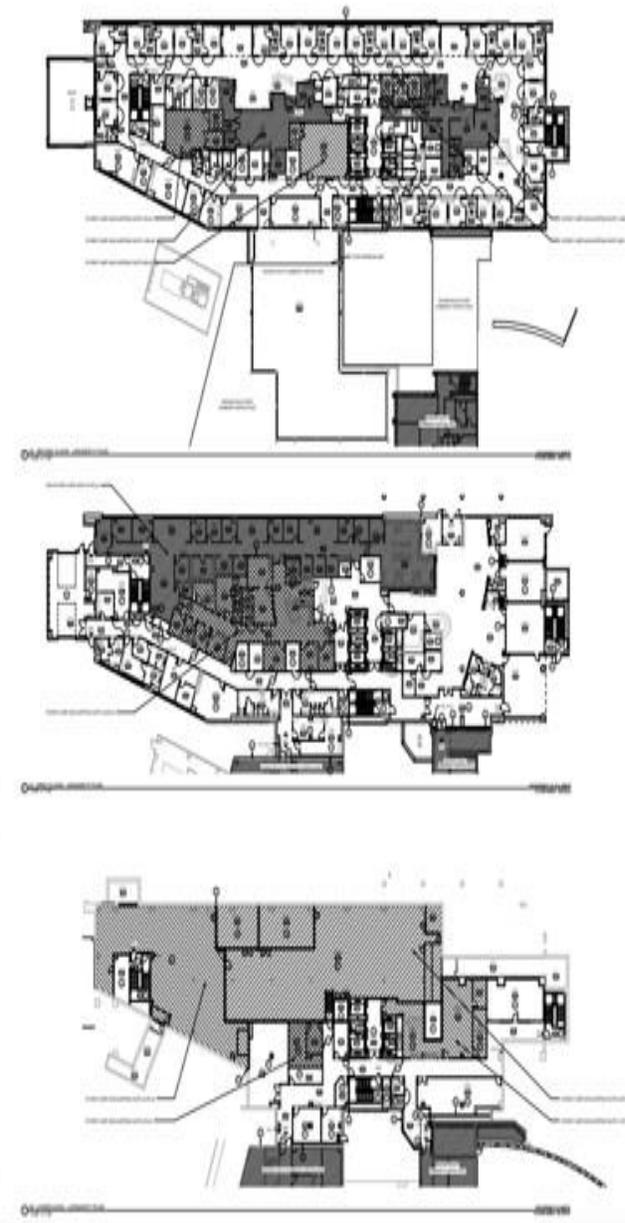
- APPENDIX 1: Damage Assessment tool
- APPENDIX 2: Emergency Protective Measures Record
- APPENDIX 3: Damage Assessment Guidelines
- APPENDIX 4: Maps of Facility and Grounds
- APPENDIX 5: Hospital Incident Management Team (HIMT)
- APPENDIX 6: State process for restoration of records
- APPENDIX 7: Emergency HIPAA
- APPENDIX 8: District 5 Healthcare Coalition General Information
- APPENDIX 9: Personnel staging screening tools
- APPENDIX 10: Evacuation Resources
- APPENDIX 11: Forms

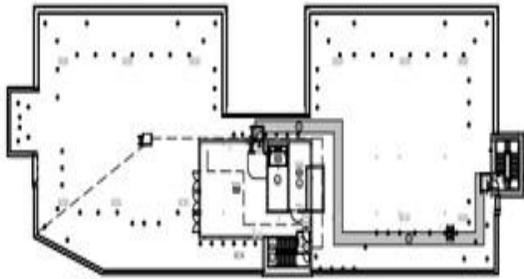
**Appendix 1: Damage Assessment Tool**

**NDI 4 - Rapid Damage Assessment Tool**

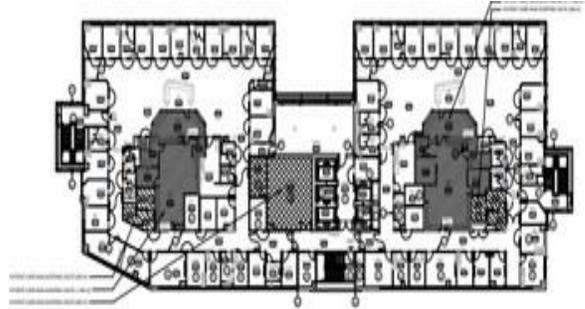
*Identify damage on drawings and provide a description in the boxes provided.*

Unit#	Destroyed/Major/Minor/Affected
Comments	
Unit#	Destroyed/Major/Minor/Affected
Comments	
Unit #	Destroyed/Major/Minor/Affected
Comments	

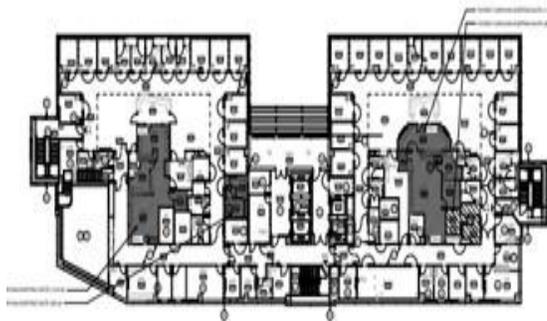




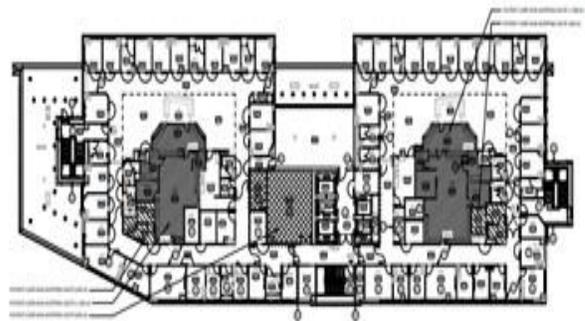
01/2017 02/2017



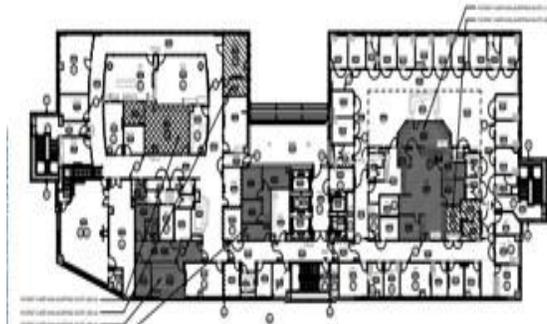
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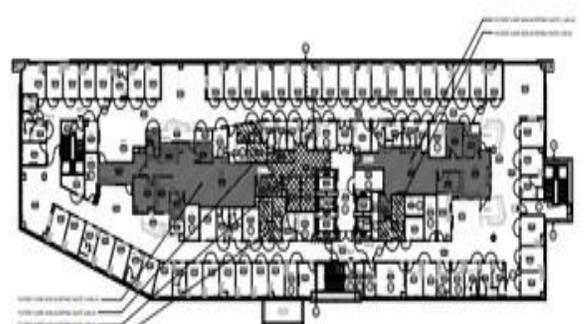
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**Appendix 3: Damage Assessment Guidelines**

**NDI HOSPITAL DAMAGE ASSESSMENT LEVEL GUIDELINES**

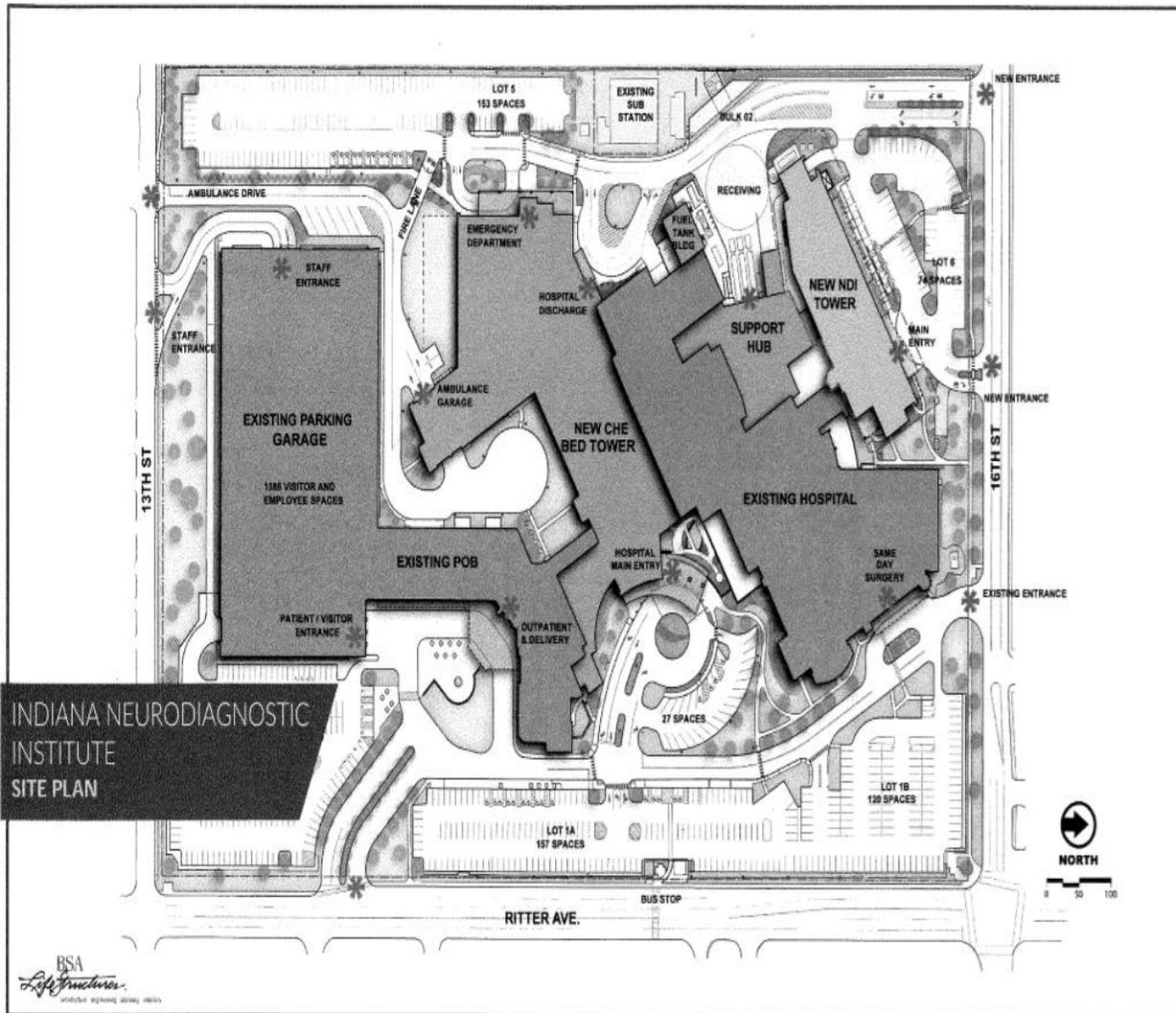
<b>Damage Definitions</b>	<b>General Description</b>	<b>Things to Look For</b>	<b>Water Levels</b>
<b>DESTROYED</b>	<b>DESTROYED</b>	<b>DESTROYED</b>	<b>DESTROYED</b>
Structure is total loss. Not economically feasible to rebuild	Structure leveled above the foundation, or second floor is gone. Foundation or basement is significantly damaged	Structure leveled or has major shifting off its foundation or only the foundation remains. Roof is gone, with noticeable distortion to walls.	More than 4 feet in first floor.
<b>MAJOR</b>	<b>MAJOR</b>	<b>MAJOR</b>	<b>MAJOR</b>
Structure is currently uninhabitable. Extensive repairs are necessary to make habitable. <b>Will take more than 30 days to repair.</b>	Walls collapsed. Exterior frame damaged. Roof off or collapsed. Major damage to utilities: boiler, chillers, water system, sewage	Portions of the roof and decking missing. Twisted, bowed, cracked, or collapsed walls. Structure penetrated by large	2-4 Feet in first floor without basement.  1 foot or more in first floor with basement.
<b>MINOR</b>	<b>MINOR</b>	<b>MINOR</b>	<b>MINOR</b>
Structure is damaged and uninhabitable. Minor repairs are needed to make habitable. <b>Will take less than 30 days to repair.</b>	Interior flooring/exterior walls with minor damage. Tree(s) fallen on structure. Smoke damage. Shingles moved or missing.	Many missing shingles, broken windows, and doors. Loose or missing siding. Minor shifting or settling of foundation.	2 inches to 2 feet in first floor without basement. 1 foot or more in basement. Sewage in basement
<b>AFFECTED HABITABLE</b>	<b>AFFECTED HABITABLE</b>	<b>AFFECTED HABITABLE</b>	<b>AFFECTED HABITABLE</b>
Structure has received minimal damage and is habitable without repairs.	Chimney or porch damaged. Carpet on first floor soaked. Broken windows.	Few missing shingles; some broken windows. Damage to air conditioning units, etc. Some minor basement flooding	Less than 2 inches in first floor. Minor basement flooding.

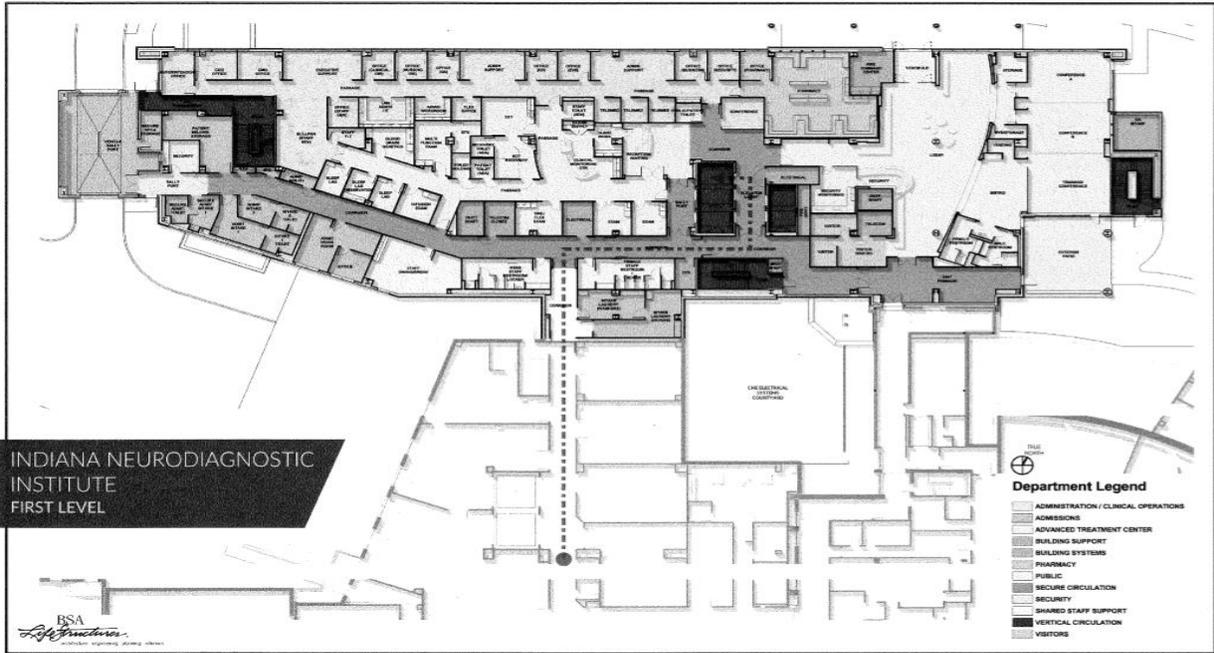
**Estimating Water Depths**

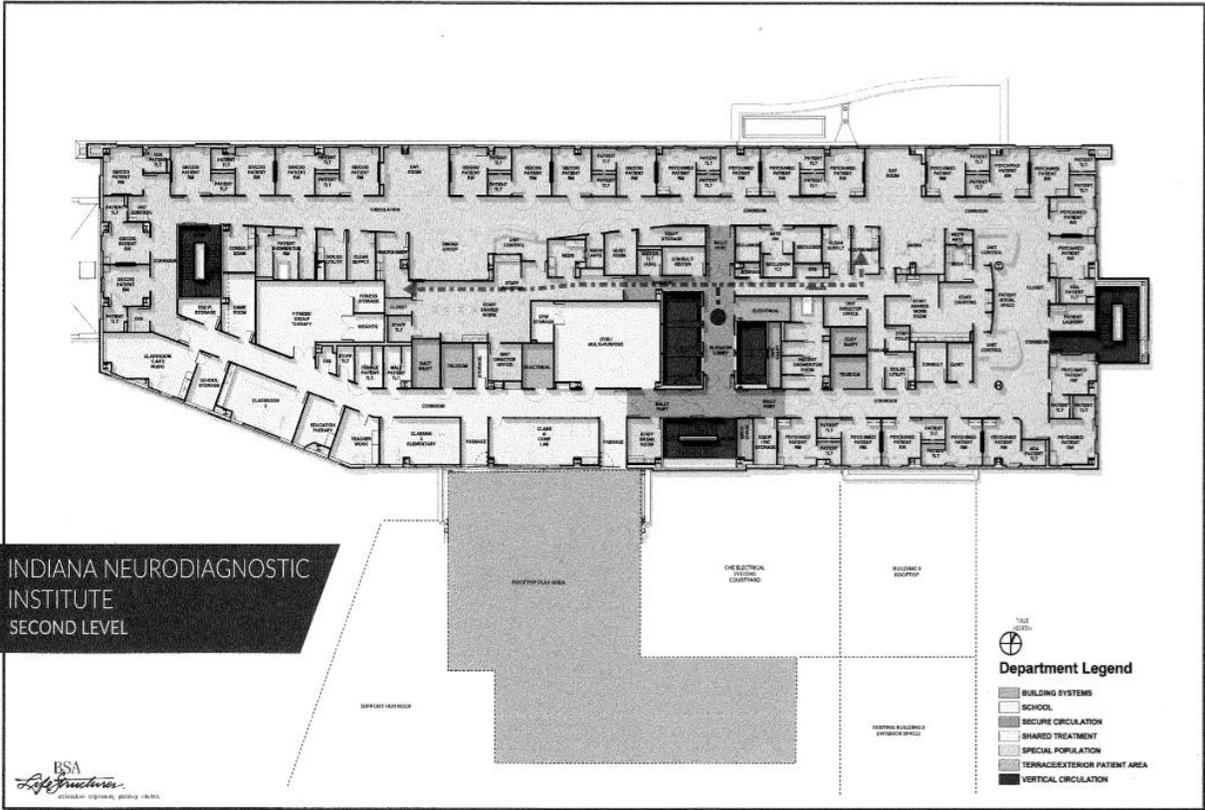
Brick – 2 ½” per course Aluminum Siding = 4” per course Stair risers = 7” Concrete block = 8” per course Door knobs = 36” above floor Standard doors = 6’ 8”

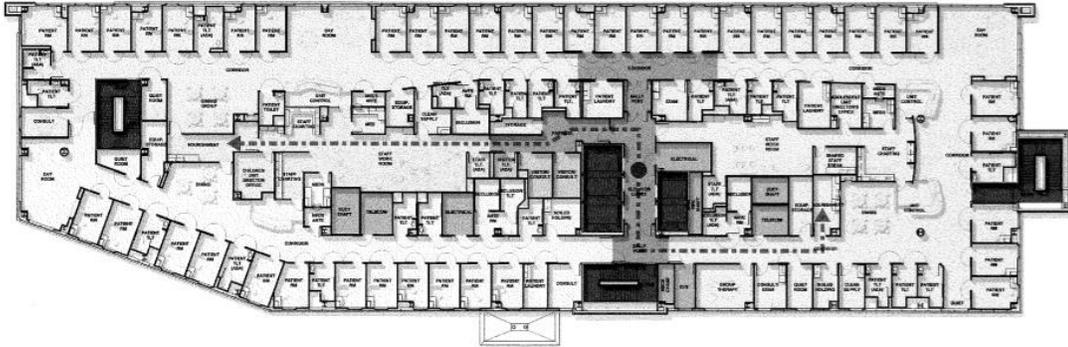
*Adapted from FEMA and Virginia Department of Management*

**Appendix 4: Maps of Facility and Grounds**







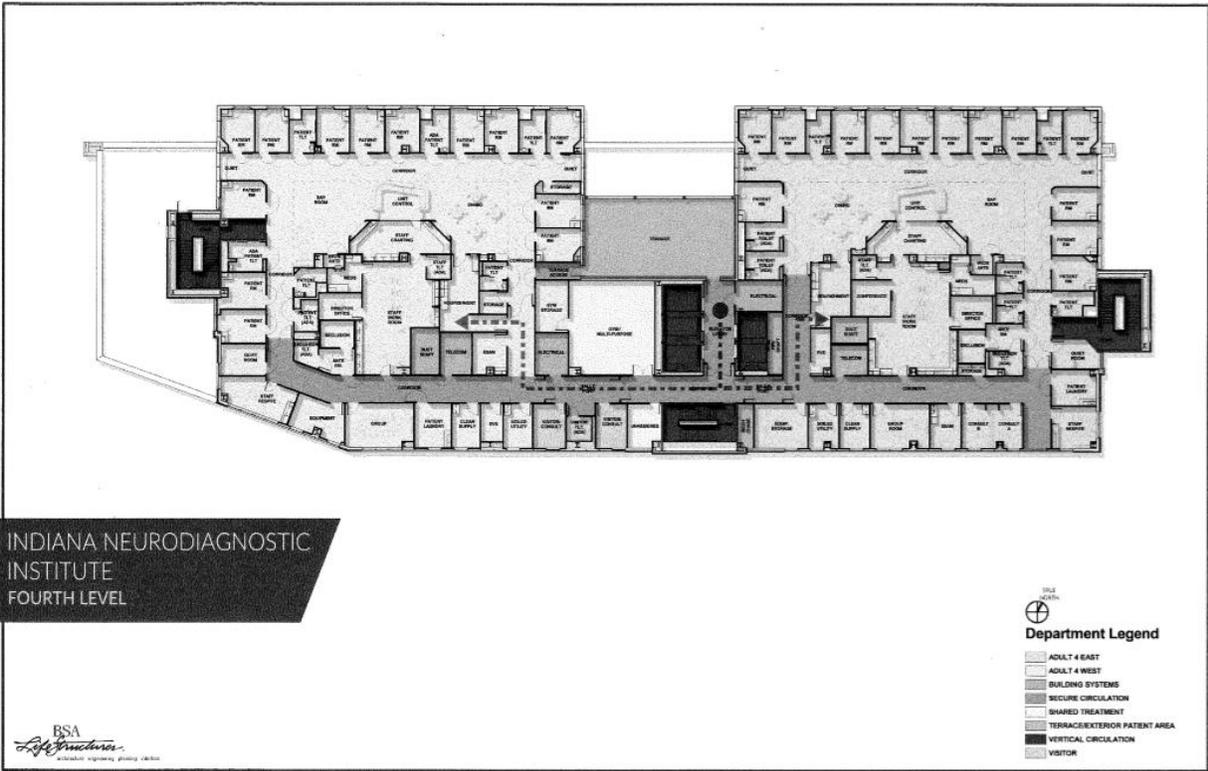


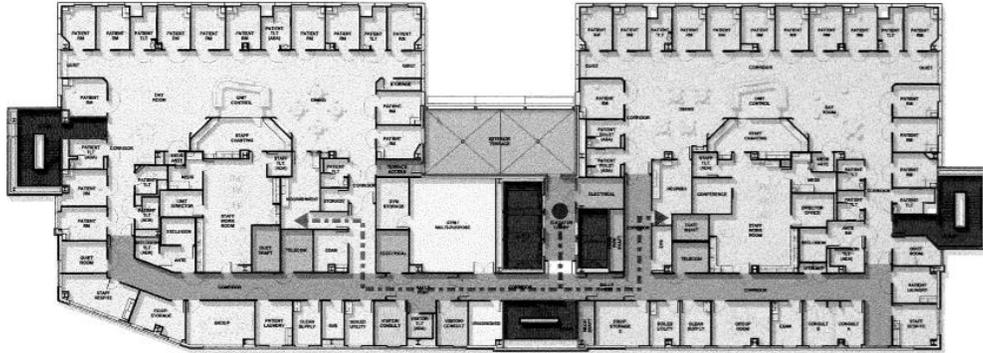
INDIANA NEURODIAGNOSTIC  
INSTITUTE  
THIRD LEVEL


  
**Department Legend**

-  ADULT/ADJACENT
-  BUILDING SYSTEMS
-  CHILDRENS
-  MATERIAL MANAGEMENT
-  SECURE CIRCULATION
-  SHARED STAFF SUPPORT (CHILD/ADOLESCENT)
-  VERTICAL CIRCULATION
-  VISITORS


  
 BSA
   
*Life Structures*
  
ARCHITECTURE INTERIORS (CORPORATE) 402101



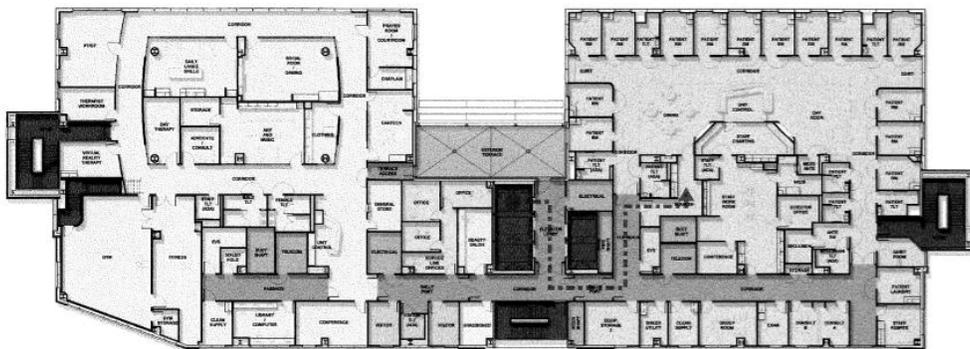


INDIANA NEURODIAGNOSTIC  
INSTITUTE  
FIFTH LEVEL


  
 Department Legend

-  ADULT S EAST
-  ADULT S WEST
-  BUILDING SYSTEMS
-  SECURE CIRCULATION
-  SHARED TREATMENT
-  TERRACE/EXTERIOR PATIENT AREA
-  VERTICAL CIRCULATION
-  VISITOR

BSA  
*Life Structures*  
ARCHITECTURE INTERIORS PLANNING INTERIORS

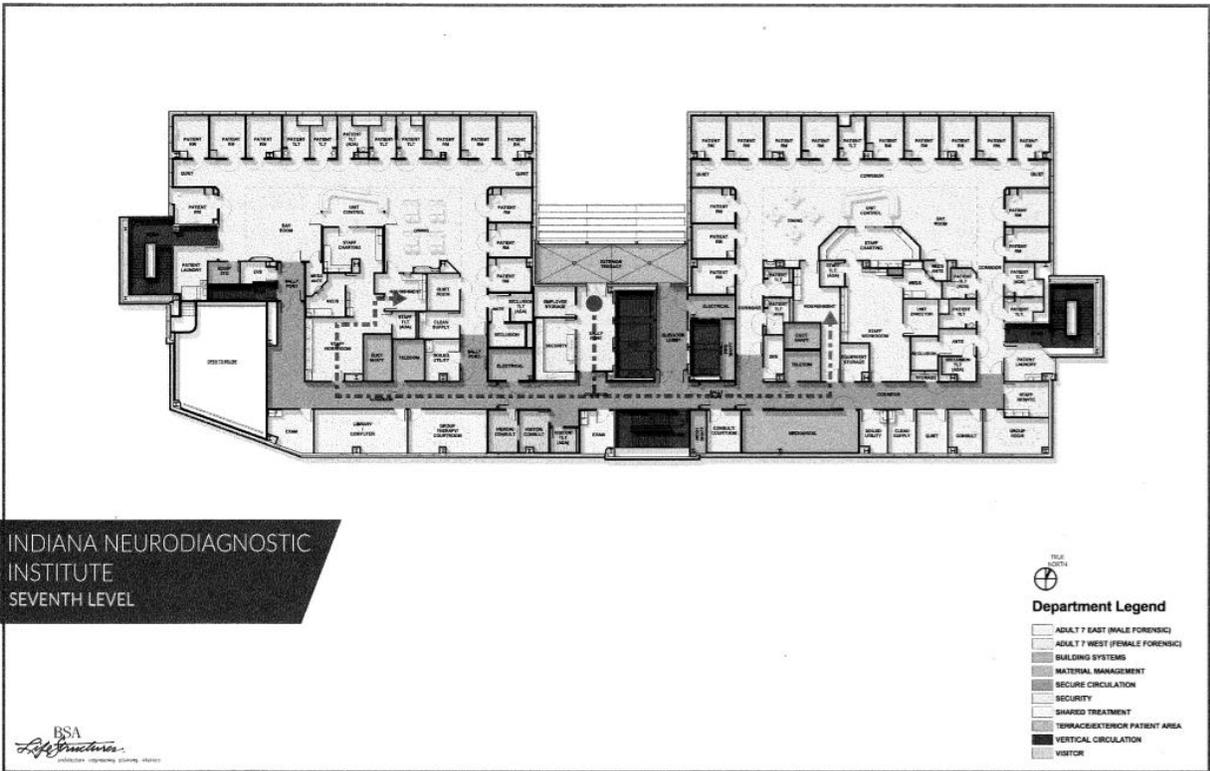


INDIANA NEURODIAGNOSTIC  
INSTITUTE  
SIXTH LEVEL

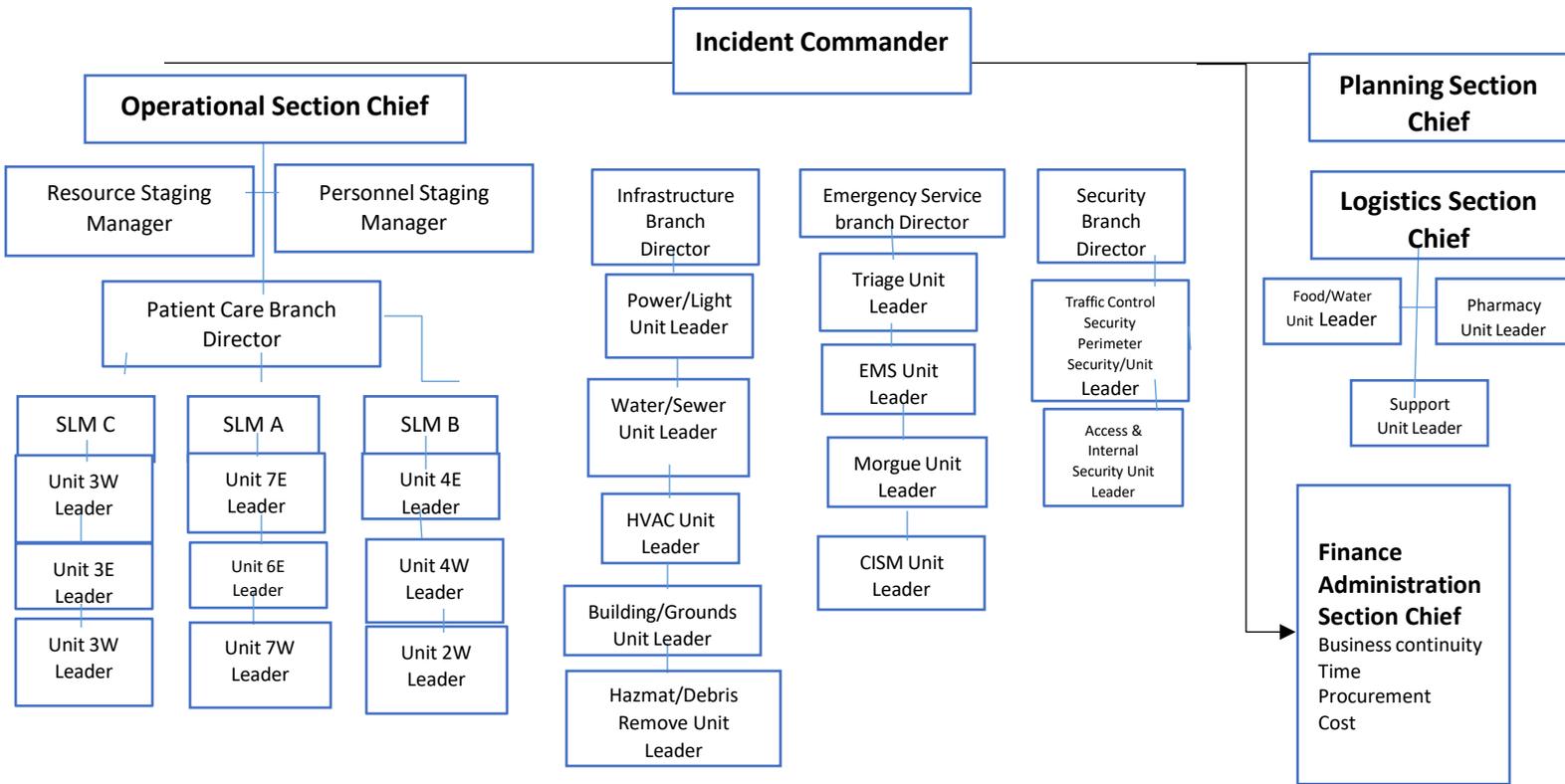



  
 Department Legend

-  ADMINISTRATION / CLINICAL OPERATIONS
-  ADULT'S WAIT
-  BUILDING SYSTEMS
-  SECURE CIRCULATION
-  SHARED TREATMENT
-  TERRACE/EXTERNAL PATIENT AREA
-  TREATMENT MALL
-  VERTICAL CIRCULATION
-  VISITOR



**Appendix 5: Hospital Incident Management Team**



## ***Appendix 6: State Process for Restoration of Records***

### **State process by which destroyed or damaged patient records can be restored**

- Destroyed: The Indiana Commission on Public Records has staff that can assist us in properly destroying these confidential records.
- Damaged: The Indiana Commission on Public Records, State Archives division, does have a conservation lab that is able to assist with the reconstruction of the records. However, depending on the severity of the damage or the amount of damaged records, we may need to acquire outside resources.

### **Emergency contact list with agency approved damage restoration companies: Shredding**

Company	Address	Telephone	Cell/Blackberry	Fax
Shares Shredding and Recycling	1611 S. Miller St., Shelbyville, IN 46176	317-398-8497	317-345-0306	317-398-4776
Opportunity Enterprises	2801 Evans Ave., Valparaiso, IN 46383	219-464-9622	219-921-6889	219-464-9636
Shred-It	50 Kowebe Ln, Indianapolis, IN 46201	317-643-4500		
Bona Vista Industries	1221 S. Plate, Kokomo, IN 46902	765-454-5344 x239		765-959-5343
Carey Services / docu-SHIELD	2724 S. Carey St., Marion, IN 46953	765-668-4992		
Knox County ARC	2525 N. 6th St., Vincennes, IN 47591	812-886-4312		812-895-0064

## Conservation / Salvage

Company	Address	Telephone	Cell/Blackberry	Fax
Document Freeze-Drying	11847 Levan Rd.; Livonia, MI 48150	(734) 464-4444	(313) 350-5555	Fax (734) 464-4050
Midwest Freeze Dry	7326 N. Central Park, Skoki, IL 60076	847-679-4756		847-697-4191
American Freeze Dry	1722 Hurffville Rd. Bldg. 2A; Five Points Business Center; Deptford, NJ 08096	866-939-8160		
Belfor	185 Oakland Ave. Ste. 300; Birmingham, MI 48009	800-856-3333		248-594-1133
Munters Moisture Control Services	PO Box 640; 79 Monroe St.; Amesbury, MA 01913	978-241-1100; 800-686-8377		978-241-1219

### Precautions the State uses to protect their paper records, whether it is from fire, water or other:

- **Fire:** Having a properly set up sprinkler system is ideal. Keep combustible documents away from heat sources. Keep all hazardous / combustible supplies locked up and away from heat sources.
- **Water:** Do not place records or boxes on the floor, raise them up at least 4 inches. Do not store paper records or boxes under pipes used for water / sewage transfer. Regularly check your stored documents for water damage and address all issues immediately.
- **Other:** Review what paper records are not currently backed up electronically. If they are not backed up and are critical records, in regards to patient care or the essential functions of the hospital, determine what steps are necessary to correct this.

## ***Appendix 7: Emergency HIPAA***

### **HIPAA Privacy and Disclosures in Emergency Situation**

Persons who are displaced and in need of health care as a result of severe disaster need ready access to health care and the means of contacting family, caregivers and gatekeepers. This bulletin emphasizes the HIPAA Privacy Rule and how it allows patient information to be shared to assist in disaster relief efforts and to assist patients in receiving the care they need.

Providers and health plans covered by the HIPAA Privacy Rule can share patient information in all the following ways:

**Treatment:** Sharing of patient information as necessary to provide treatment. Example- Hospitals, Clinics, Linking patients with providers if relocation of patient occurs, emergency relief workers, or others that help find patients appropriate health services.

**Notification:** Sharing of patient information as necessary to identify, locate and notify family, guardians, gatekeepers, or anyone else responsible for the individual's location, general condition, or death. Example- Hospital may notify police, press, or the public to the extent necessary to help locate, identify or notify family and others as to the location and condition of patients. This also covers sharing information with disaster relief organizations that are lawfully allowed to assist in disaster relief efforts.

**Imminent Danger:** Sharing of patient information with anyone to prevent or lessen a serious and imminent threat to the health and safety of a person or the public according to our facility code of ethics and bylaws.

**Facility Directory:** Directory of patients can be used to tell people who inquire about individuals, whether the individual is at the facility, their location and condition.

#### **In the event of Destroyed Medical Records**

Medicaid and Medicare providers, who are subject to a payment error rate measure testing (CERT) review, may obtain administrative relief from the Department of Health and Human Services (DHHS) if records are completely or partially destroyed due to a natural disaster. This allows providers a shift in the time period of the claims being reviewed to a later time period and a suspension of the review for documentation of the disaster as required by DHHS. In some cases if complete destruction occurs, DHHS would accept an attestation that no medical records exist and consider the services covered. In this case providers should reconstruct records as best as they can. Records must note "This record was reconstructed because of natural disaster". DHHS requires Medicare and

Medicaid beneficiaries receive the emergency or urgent services that they need.

## **Appendix 8: District 5 Healthcare Coalition General Information and Communications Plan**



### **OUR MISSION**

The District 5 Healthcare Coalition's mission is to support medical and healthcare entities prepare for, respond to, and recover from disasters through information sharing and resource support in Indiana District 5 region.

### **OUR VISION**

To build and strengthen relationships among medical and healthcare partners.

### **WHO WE ARE**

The District 5 Healthcare Coalition is a collaborative network of healthcare organizations and their respective emergency management personnel. D5 HCC serves as a multidisciplinary, multi-agency group that assists in the coordination with local Emergency Function (ESF) #8 of the National Response Framework with preparedness, response, recovery and mitigation.

Working with the appropriate level of emergency operations providers by sharing information among them to promote common situational awareness.

Supporting the needs of healthcare organizations through collaboration of coalition partners' various Emergency Management Meetings

Meeting community needs by promoting the quality of disaster patient/victim care services and improving disaster response

Developing and implementing effective practices including continuity planning, education, training and drills

Serve to strengthen and sustain the public health and medical response system by properly analyzing and planning

Promoting healthcare providers' capacity to anticipate the plan of care in the event of a medical surge

The District 5 Hospital Preparedness Planning Committee began in the early 2000s when the hospitals in the region began to discuss emergency plans for the region. This Coalition formalized into a not-for-profit corporation which coordinates the needs of Healthcare organizations throughout the region.

In 2018, the coalition expanded its membership to include the recognized Core 4 agencies (Hospital, Public Health, Emergency Management, and Fire) along with other healthcare entities in the district. The coalition is sponsored by a federal grant from the Assistant Secretary for Health & Human Services Office to fund emergency preparedness projects and activities. This new coalition

## Appendix 9: Personnel Staging Screening Tools

To screen for arrest record:

mycase.IN.gov

▲ MyCase will be offline for maintenance on Saturday December 31st from 5:00 AM to ~8:00 AM.

### Case Search (beta)

Search for non-confidential cases in Indiana courts that use the Odyssey case management system. This site replaces the original version previously available at mycase.in.gov. Tell us what you think of the new site.

Search by **Case** Party Attorney

Person

Last  First  Middle

Birth Date

-or-

Business

Sounds-like  Enable sounds-like searching for last, first and/or middle name ?

Court

Limit search to

- Criminal & Citation
- Civil
- Family
- Probate
- Appellate
- Commercial

To screen for sexual offenses: [https://sheriffalerts.com/cap\\_main.php?office=54234](https://sheriffalerts.com/cap_main.php?office=54234)



**MARION**  
County Sheriff's Office

Sheriff  
Kerry Forestal

Search for Offenders in your area

Register for Email Alerts

Safety Tips

Links

Contact

Welcome

Our office is pleased to provide *OffenderWatch*® for the citizens of Marion County. *OffenderWatch*® is the nation's leading registered sex offender management and community notification tool with hundreds of leading agencies in dozens of states utilizing it. Marion County's law enforcement utilizes *OffenderWatch*® to manage and monitor the whereabouts, conduct and compliance status of the registered offenders in Marion County. *OffenderWatch*® provides the most accurate and timely information available and now this information is available to you!

*OffenderWatch*® is updated instantaneously throughout the day as offender addresses and other offender information is updated in our office. You may enter any address in the County and see real-time information on the publishable offenders within the specified radius of the address you enter.

Offenders move frequently, so instead of having to check the maps on a weekly basis, the best way to stay informed is to take advantage of our free email alert system. You may confidentially register as many addresses in the County as you wish, and we will continuously monitor the addresses and send you an email alert if a new offender registers an address within the specified radius of any address you register. There is no cost for this service and no limit to the number of addresses you can register - your email address and physical addresses are all confidential. Tell your friends and neighbors and be sure to register your home, school, work, gym, day care, park, soccer field, parents or children's homes - any address of interest to you!

[Click Here To Search For Offenders In Your Area.](#)

To check for licensed independent practitioners: <https://mylicense.in.gov/everification/Search.aspx>



### Search for a License

Welcome to Web Lookup/Verification

- Please enter search criteria below to start your search (enter data in any field- we will search with whatever information you provide to us- remember less is more!)
- If you have partial information, or not sure of the exact name etc., **you may use a wildcard search by placing a "\*" following the partial data entered** (example - not sure if Alan or Allen, enter Al\*) to search.
- Click [here](#) to search for a Facility instead of a person.

Search Criteria

Profession: <input type="text" value="All"/>	First/Mid Name: <input type="text"/>
License Type: <input type="text" value="All"/>	Last Name: <input type="text"/>
Attribute Type: <input type="text" value="All"/>	City: <input type="text"/>
License Number: <input type="text"/>	State: <input type="text" value="--All--"/>
License Status: <input type="text" value="All"/>	County: <input type="text"/>
Doing Business As: <input type="text"/>	Zipcode: <input type="text"/>

**Appendix 10: Evacuation Resources**

**HICS 255 - MASTER PATIENT EVACUATION TRACKING**

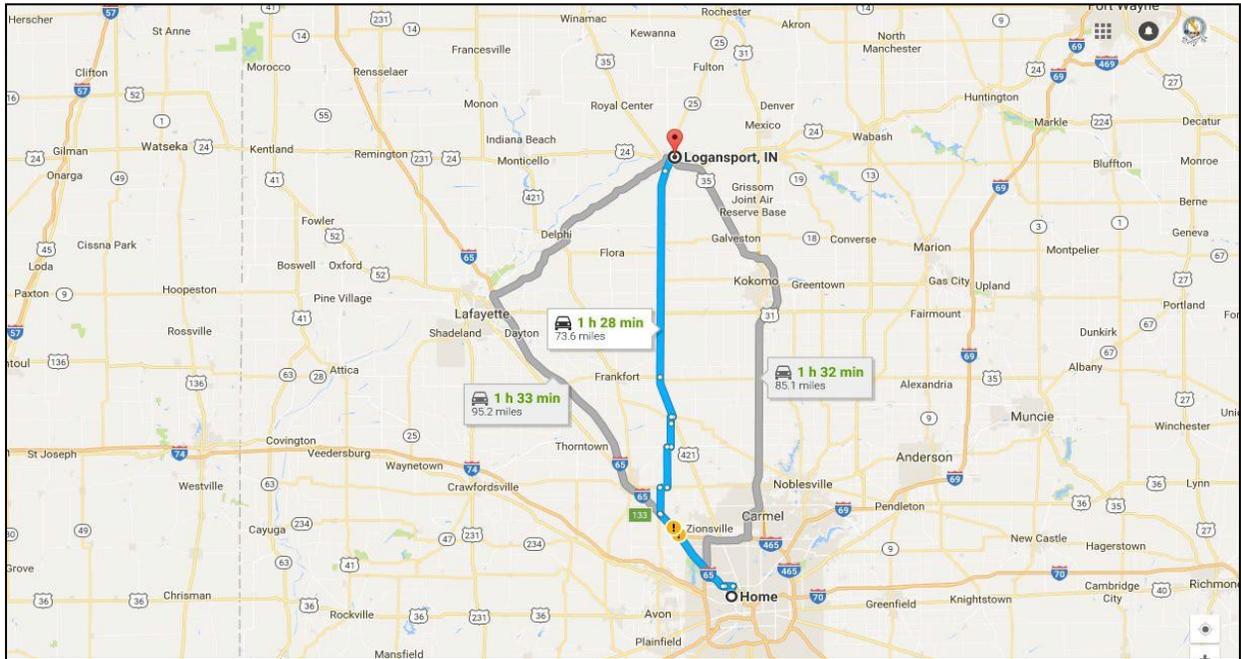
<b>1. Incident Name</b>		<b>2. Operational Period (# )</b> DATE: FROM: _____ TO: _____ TIME: FROM: _____ TO: _____					
<b>3. Patient Evacuation Information</b>							
<b>PATIENT NAME</b>	<b>Medical Record #</b>	<b>Evacuation Triage Category</b> <small>IMMEDIATE DELAYED MINOR</small>	<b>Mode of Transport</b> CCT ALB BLB VAN BUS CAR AIRCRAFT				
	<b>Disposition</b> <small>DISCHARGE/ TRANSFER/MORGUE</small>	<b>Accepting Hospital or Location</b>					
<b>Transfer Initiated (Time/Transport Co./ #)</b>	<b>Medical Record Sent</b> YES NO	<b>Family Notified</b> YES NO	<b>Arrival Confirmed</b> YES NO	<b>Admit Location</b> FLOOR ICU ER MORGUE	<b>Expired (time)</b>		
<b>PATIENT NAME</b>	<b>Medical Record #</b>	<b>Evacuation Triage Category</b> <small>IMMEDIATE DELAYED MINOR</small>		<b>Mode of Transport</b> CCT ALB BLB VAN BUS CAR AIRCRAFT			
	<b>Disposition</b> <small>DISCHARGE/ TRANSFER/MORGUE</small>	<b>Accepting Hospital or Location</b>					
<b>Transfer Initiated (Time/Transport Co./ #)</b>	<b>Medical Record Sent</b> YES NO	<b>Family Notified</b> YES NO	<b>Arrival Confirmed</b> YES NO	<b>Admit Location</b> FLOOR ICU ER MORGUE	<b>Expired (time)</b>		
<b>PATIENT NAME</b>	<b>Medical Record #</b>	<b>Evacuation Triage Category</b> <small>IMMEDIATE DELAYED MINOR</small>		<b>Mode of Transport</b> CCT ALB BLB VAN BUS CAR AIRCRAFT			
	<b>Disposition</b> <small>DISCHARGE/ TRANSFER/MORGUE</small>	<b>Accepting Hospital or Location</b>					
<b>Transfer Initiated (Time/Transport Co./ #)</b>	<b>Medical Record Sent</b> YES NO	<b>Family Notified</b> YES NO	<b>Arrival Confirmed</b> YES NO	<b>Admit Location</b> FLOOR ICU ER MORGUE	<b>Expired (time)</b>		
<b>PATIENT NAME</b>	<b>Medical Record #</b>	<b>Evacuation Triage Category</b> <small>IMMEDIATE DELAYED MINOR</small>		<b>Mode of Transport</b> CCT ALB BLB VAN BUS CAR AIRCRAFT			
	<b>Disposition</b> <small>DISCHARGE/ TRANSFER/MORGUE</small>	<b>Accepting Hospital or Location</b>					
<b>Transfer Initiated (Time/Transport Co./ #)</b>	<b>Medical Record Sent</b> YES NO	<b>Family Notified</b> YES NO	<b>Arrival Confirmed</b> YES NO	<b>Admit Location</b> FLOOR ICU ER MORGUE	<b>Expired (time)</b>		
<b>4. Prepared by</b>	<b>PRINT NAME:</b> _____	<b>SIGNATURE:</b> _____		<b>FACILITY:</b> _____			
	<b>DATE/TIME:</b> _____						



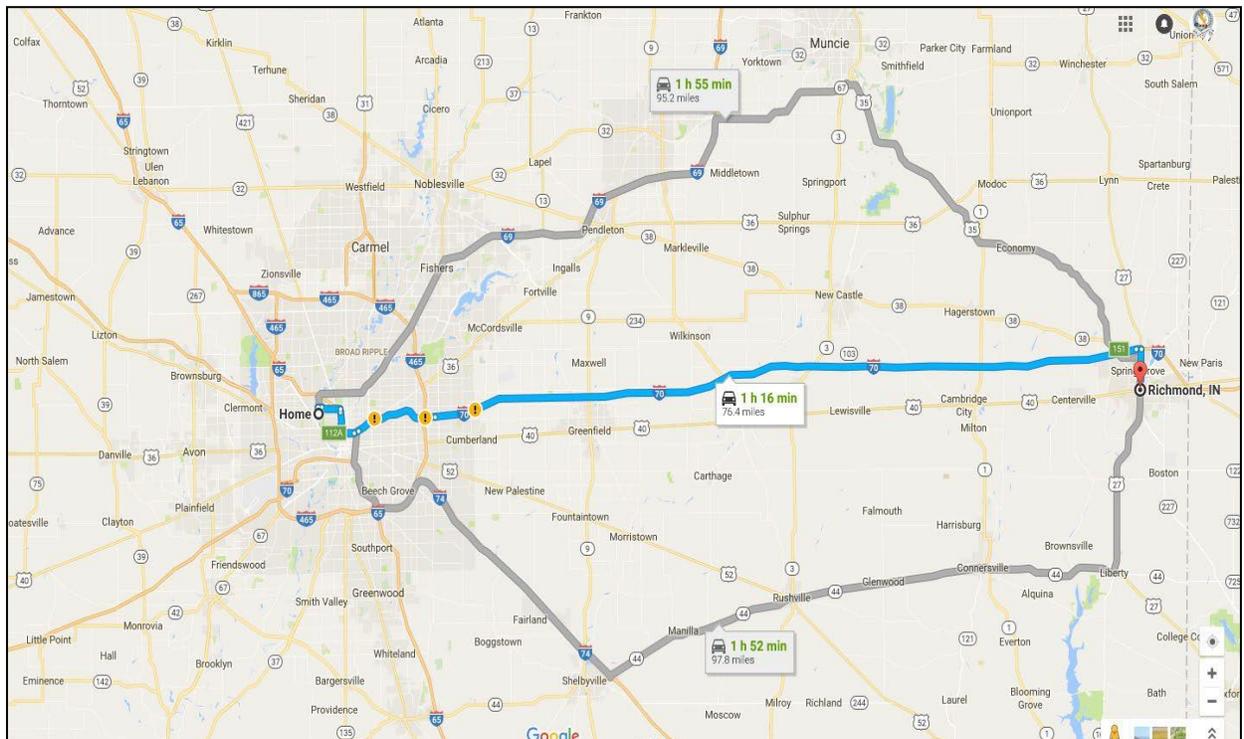
Purpose: Record information concerning patient disposition during an evacuation  
 Originator: Situation Unit Leader or designee (Patient Tracking Manager)  
 Copies to: Planning Section Chief, Documentation Unit Leader

## Evacuation Routes / Times

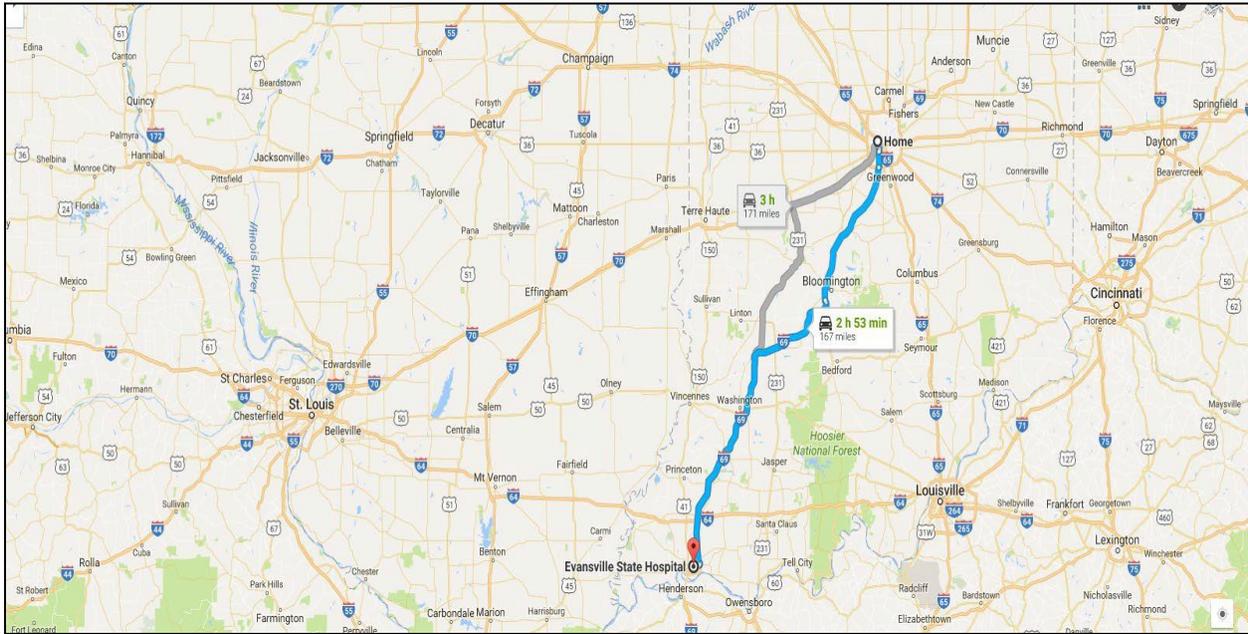
### Logansport SPH



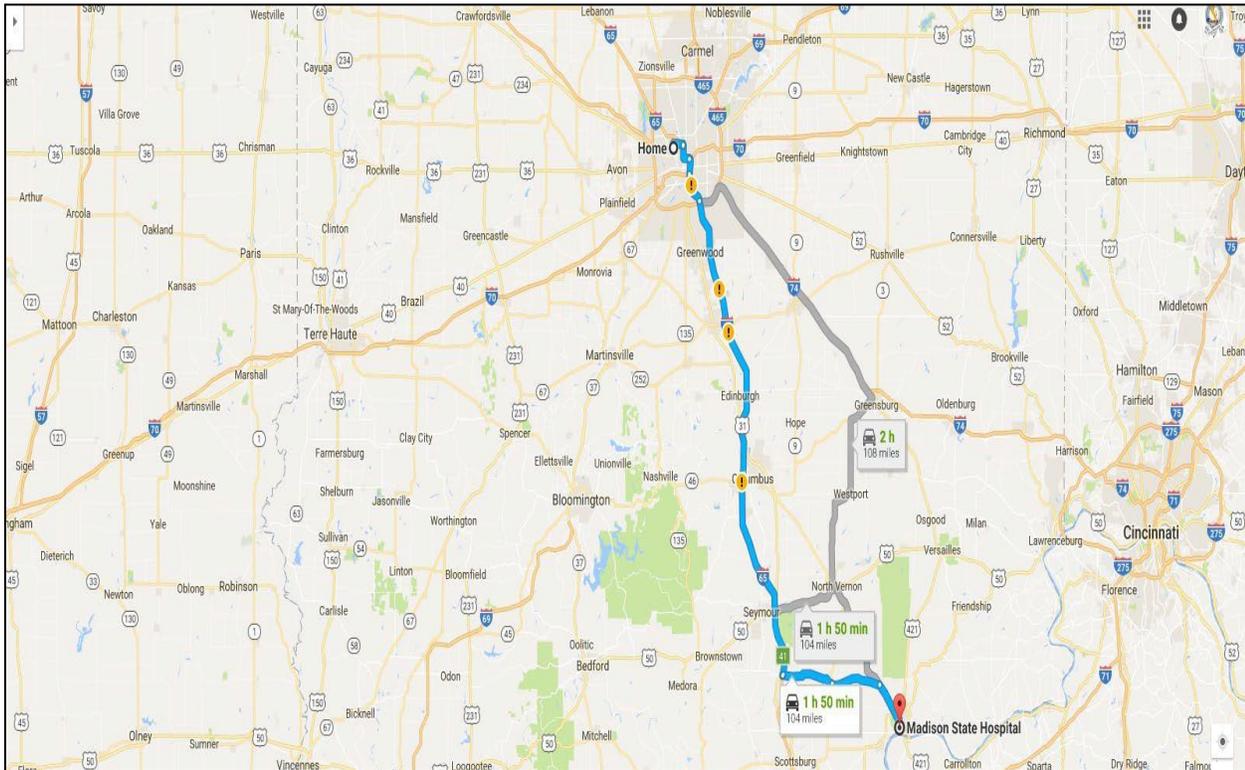
### Richmond SPH



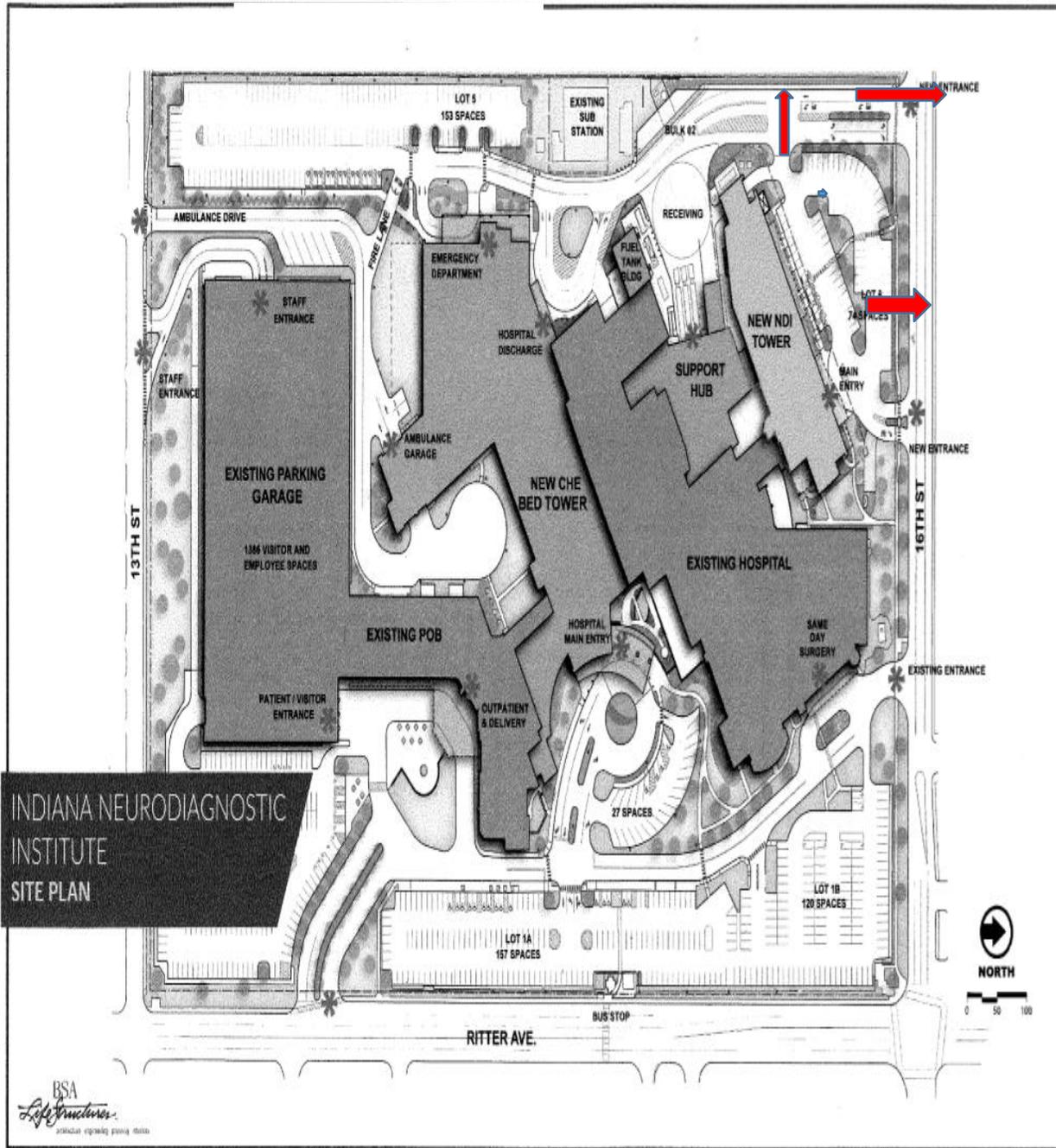
## Evansville SPH



## Madison SPH



# Hospital Grounds Evacuation Map



## **Appendix 11: Forms**

### **Initial Response**

NDI 1 – *Incident Cover Sheet*

NDI 2 – *Incident Activation*

NDI 3 – *Initial Size-up*

NDI 4 – *Damage Assessment*

NDI 7 – *Initial Situation and Resource Status Report*

### **Operational Response**

NDI 5 – *HIMT Organizational Chart*

HICS – *Incident Action Plan (IAP) QuickStart*

NDI 6 – *Organizational Assignment List*

NDI 8 – *Common Operating Picture*

NDI 9 – *Planning Cycle Worksheet*

HICS 201 – *Incident Briefing*

HICS 221 – *Demobilization Check-Out*

HICS 213 – *Resource Request Message*

### **General**

HICS 213 – *General Message*

HICS 214 – *Activity Log*

HICS 252 – *Section Personnel Time Sheet*

Forms located: <L:\Emergency Management Resources\Incident Response\Forms\Forms\NDI Forms>